



Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource

<b>MEDICAL POLICY STATEMENT</b>	
<b>North Carolina Marketplace</b>	
Policy Name & Number	Date Effective
Neonatal Discharge Criteria-NC MP-MM-1412	11/01/2023
Policy Type	
<b>MEDICAL</b>	

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Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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## A. Subject

### Neonatal Discharge Criteria

## B. Background

Infants who require neonatal admission remain at increased risk for morbidity and mortality following discharge. These infants require comprehensive discharge planning to ensure a smooth transition from the neonatal intensive care unit (NICU) and to reduce morbidity and mortality after discharge.

Despite the inability to predict the exact timing of a NICU discharge, discharge planning should begin at NICU admission in an effort to avoid overwhelming parents and hospital staff. This planning will aid in minimizing discharge delays and will promote safe and healthy discharges to home.

Discharge may be appropriate when the establishment of physiologic competencies, including, but not limited to, thermoregulation, feeding, respiratory control, and stability regardless of weight or corrected gestational age, have been achieved.

## C. Definitions

- **Acceptable Bilirubin Level** – Defined per American Academy of Pediatrics (AAP) guidelines.
- **Bilirubin** – Blood test to measure liver function.
- **Car Seat Test Eligibility** – < 37 weeks gestation or at risk for respiratory compromise.
- **Feeding Difficulties** – Minimal or no ability to feed orally.
- **Oral (PO) Feeding** – By mouth feeding.
  - **Adequate PO Feeding** – Ingesting sufficient oral feeding to support adequate or appropriate growth.
- **Stable Body Temperature** – Ability to maintain body temperature > 36.4 C axillary while clothed in an open bed/ crib.

## D. Policy

- I. CareSource considers neonatal discharge medically appropriate for **non-technology dependent** infants when **ALL** of the following clinical criteria are met:

### A. Thermoregulation Stability

1. Infant demonstrates the ability to maintain normal body temperature while clothed in an open crib. Up to 48 hours of stable body temperature is typically adequate for infants born < 37 weeks gestation.
2. 12 hours of stable body temperature is adequate for infants born  $\geq$  37 weeks.
3. For infants placed in an isolette solely for the purpose of phototherapy and not thermoregulation, additional observation is not required once treatment is completed.

### B. Cardio-Respiratory Stability

1. Infant is stable on room air after discontinuation of oxygen therapy for up to 48 hours.

2. If infant was on caffeine, he/she has been observed for apnea for 5 days off caffeine
  3. Event countdown
    - The infant has not had any clinically significant apnea/bradycardia/desaturation (A/B/D) episodes for 5-7 days. An event is considered clinically significant if the infant required stimulation
    - The infant has not had any self-resolved B/D events in the last 48 hours
    - Note: Isolated bradycardia events that are associated with feeding should not delay discharge as these are observed events with a known cause
  4. Infant passed car seat test, if applicable.
- C. Feeding and Adequate Weight Gain
1. Infant demonstrates adequate PO feeding by bottle or breast for up to 48 hours.
  2. Overall weight gain is adequate, as expected for gestational age and day of life.
- D. Bilirubin
1. Acceptable level based on hours of life per AAP Bilitool (Bilitool.org) and
  2. Risk factors include the following:
    - a. gestational age < 38 weeks (risk increases with the degree of prematurity)
    - b. albumin < 3.0 g/dL
    - c. isoimmune hemolytic disease (ie, positive direct antiglobulin test), G6PD deficiency, or other hemolytic conditions
    - d. sepsis
    - e. significant clinical instability in the previous 24 hours
- II. CareSource considers neonatal discharge medically appropriate for **technology dependent** infants when **ALL** of the following clinical criteria are met:
- A. Cardio-Respiratory Stability
1. Infant is stable, but has one or more of the following conditions:
    - a. Bronchopulmonary dysplasia (BPD) and is on low flow nasal cannula at any oxygen concentration with a flow rate of  $\leq 0.5$  LPM (liters per minute).
    - b. Infant has tracheostomy and requires positive pressure ventilation. Ventilator settings are stable and fraction of inspired O<sub>2</sub> is < 40% utilizing a home ventilator.
- B. Feeding and Adequate Weight Gain
1. Infant is stable but has one of the following conditions:
    - a. Infant has feeding difficulties and is dependent on gastrostomy and nasogastric tube feedings. Appropriate home health care and family teaching has been completed.
- E. Conditions of Coverage  
NA
- F. Related Policies/Rules  
NA

### G. Review/Revision History

	DATE	ACTION
<b>Date Issued</b>	01/04/2023	New policy
<b>Date Revised</b>	07/19/2023	Updated D. I. B. 2. 3. Updated references. Approved at Committee
<b>Date Effective</b>	11/01/2023	
<b>Date Archived</b>		

### H. References

1. American Academy of Pediatrics Committee on Fetus and Newborn. Hospital discharge of the high-risk neonate. *Pediatrics*. 2008;122(5):1119-1126. doi:10.1542/peds.2008-2174.
2. American Academy of Pediatrics Committee on Infectious Diseases; American Academy of Pediatrics Bronchiolitis Guidelines Committee. Updated guidance for palivizumab prophylaxis among infants and young children at increased risk of hospitalization for respiratory syncytial virus infection. *Pediatrics*. 2014;134(2):415-420. doi:10.1542/peds.2014-1665.
3. Benitz WE; Committee on Fetus and Newbor; American Academy of Pediatrics. Hospital stay for healthy term newborn infants. *Pediatrics*. 2015;135(5):948-953. doi:10.1542/peds.2015-0699.
4. Brooten D, Kumar S, Brown LP, et al. A randomized clinical trial of early hospital discharge and home follow-up of very-low-birth-weight infants. *N Engl J Med*. 1986;315(15):934-9. doi:10.1056/NEJM198610093151505.
5. Buchman AL. Complications of long-term home total parenteral nutrition: their identification, prevention and treatment. *Dig Dis Sci*. 2001;46(1):1-18. doi:10.1023/a:1005628121546.
6. Casiro OG, McKenzie ME, McFadyen L, et al. Earlier discharge with community-based intervention for low-birth-weight infants: a randomized trial. *Pediatrics*. 1993;92(1):128-134.
7. Davies DP, Haxby V, Herbert S, McNeish AS. When should pre-term babies be sent home from neonatal units? *Lancet*. 1979;1(8122):914-915. doi:10.1016/s0140-6736(79)91386-2.
8. Eichenwald EC; AAP COMMITTEE ON FETUS AND NEWBORN. Apnea of Prematurity. *Pediatrics*. 2016;137(1):e20153757
9. Garg M, Kurzner SI, Bautista DB, Keens TG. Clinically unsuspected hypoxia during sleep and feeding in infants with bronchopulmonary dysplasia. *Pediatrics*. 1988;81(5):635-642.
10. Groothuis JR, Rosenberg AA. Home oxygen promotes weight gain in infants with bronchopulmonary dysplasia. *Am J Dis Child*. 1987;141(9):992-995. doi:10.1001/archpedi.1987.04460090069028.
11. Halliday HL, Dumpit FM, Brady JP. Effects of inspired oxygen on echocardiographic assessment of pulmonary vascular resistance and myocardial contractility in bronchopulmonary dysplasia. *Pediatrics*. 1980;65(3):536-540.
12. Jefferies AL; Canadian Paediatric Society; Fetus and Newborn Committee. Going home: Facilitating discharge of the preterm infant. *Paediatr Child Health*. 2014;19(1):31-42.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

13. Kemper AR, Newman TB, Slaughter JL, et al. Clinical practice guideline revision: management of hyperbilirubinemia in the newborn infant 35 or more weeks of gestation. *Pediatrics*. 2022;150(3):e2022058859. doi: 10.1542/peds.2022-058859
14. Moyer-Mileur LJ, Nielson DW, Pfeffer KD, Witte MK, Chapman DL. Eliminating sleep associated hypoxemia improves growth in infants with bronchopulmonary dysplasia. *Pediatrics*. 1996;98(4 Pt 1):779-783.
15. Muchowski KE. Evaluation and treatment of neonatal hyperbilirubinemia. *Am Fam Physician*. 2014;89(11):873-878.
16. Ortenstrand A, Waldenström U, Winbladh B. Early discharge of preterm infants needing limited special care, followed by domiciliary nursing care. *Acta Paediatr*. 1999;88(9):1024-1030. doi:10.1080/08035259950168568.
17. Ortenstrand A, Winbladh B, Nordström G, Waldenström U. Early discharge of preterm infants followed by domiciliary nursing care: parents' anxiety, assessment of infant health and breastfeeding. *Acta Paediatr*. 2001;90(10):1190-1195. doi:10.1080/080352501317061639.
18. Pinney MA, Cotton EK. Home management of bronchopulmonary dysplasia. *Pediatrics*. 1976;58(6):856-859.
19. Schneiderman R, Kirkby S, Turenne W, Greenspan J. Incubator weaning in preterm infants and associated practice variation. *J Perinatol*. 2009;29(8):570-574. doi:10.1038/jp.2009.54.
20. Sekar KC, Duke JC. Sleep apnea and hypoxemia in recently weaned premature infants with and without bronchopulmonary dysplasia. *Pediatr Pulmonol*. 1991;10(2):112-116. doi:10.1002/ppul.1950100213.
21. Smith VC, Stewart J. Discharge planning for high-risk newborns. Accessed April 10, 2023. [www.uptodate.com](http://www.uptodate.com).
22. Zecca E, Corsello M, Priolo F, et al. Early weaning from incubator and early discharge of preterm infants: randomized clinical trial. *Pediatrics*. 2010;126(3):e651-e656. doi:10.1542/peds.2009-3005.

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