MEDICAL POLICY STATEMENT
West Virginia Marketplace

Policy Name & Number	Date Effective
Neonatal Discharge Criteria-WV MP-MM-1247	05/01/2022
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

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 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 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

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

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 up to 48 hours of stable body temperature while clothed in an open crib is typically adequate for infants born < 37 weeks gestation.
2. 12 hours of stable body temperature is adequate for infants born ≥ 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. Infant is apnea and bradycardia-free for 5 to 7 days off caffeine therapy, if applicable.
3. 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, if weight gain is expected for gestational age and day of life.

D. Bilirubin
1. Acceptable level based on hours of life and risk factors (late preterm infant, ABO incompatibility, RH disease).

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 ≤ 0.5 LPM (liters per minute).
b. Tracheostomy and requires positive pressure ventilation and ventilator settings are stable and fraction of inspired O2 is < 40% utilizing a home ventilator.

B. Feeding and Adequate Weight Gain:
1. Infant is stable but has one of the following conditions:
a. Feeding difficulties and dependent on gastrostomy tube feedings.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	02/02/2022	New policy
Date Revised		
Date Effective	05/01/2022	
Date Archived		

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 [published correction appears in Pediatrics. 2014 Dec;134(6):1221]. Pediatrics. 2014;134(2):415-420. doi:10.1542/peds.2014-1665.

3. Benitz WE; Committee on Fetus and Newborn, 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, Butts P, Finkler SA, Bakewell-Sachs S, Gibbons A, Delivoria-Papadopoulos M. A randomized clinical trial of early hospital discharge and home follow-up of very-low-birth-weight infants. N Engl J Med. 1986 Oct 9;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 Apr 28;1(8122):914-5. doi:10.1016/s0140-6736(79)91386-2.
8. 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.
9. Groothuis JR, Rosenberg AA. Home oxygen promotes weight gain in infants with bronchopulmonary dysplasia. Am J Dis Child. 1987 Sep;141(9):992-5. doi:10.1001/archpedi.1987.04460090069028. PMID: 3618573.
10. 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.
11. 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.
12. Moyer-Mileur LJ, Nielson DW, Pfeffer KD, Witte MK, Chapman DL. Eliminating sleepassociated hypoxemia improves growth in infants with bronchopulmonary dysplasia. Pediatrics. 1996;98(4 Pt 1):779-783.
13. Muchowski KE. Evaluation and treatment of neonatal hyperbilirubinemia. Am Fam Physician. 2014;89(11):873-878.
14. 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.
15. 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.
16. Pinney MA, Cotton EK. Home management of bronchopulmonary dysplasia. Pediatrics. 1976;58(6):856-859.

17. 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.
18. 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.
19. Smith VC and Stewart J. Discharge planning for high-risk newborns. UpToDate. Updated 7/20/2021. Accessed 12/06/2021.
20. Zecca E, Corsello M, Priolo F, Tiberi E, Barone G, Romagnoli C. 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.

Independent medical review –12/27/2021