

Clinical Policy: NICU Discharge Guidelines

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[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Infants who require neonatal admission remain at increased risk for morbidity and mortality following discharge. A comprehensive discharge plan for these infants helps prevent prolonged hospital stays, ensures a smooth transition home from the neonatal intensive care unit (NICU), and reduces morbidity and mortality after discharge.⁵

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that infants are considered medically ready for discharge if the following physiologic competencies in I through V and care competencies in VI are met, or for a lower level of care, if the authorization protocol is met:

I. Sufficient nutrition to support appropriate growth, both of the following:

- A. Adequate pattern of weight gain, one of the following:
 - 1. Preterm infants or term infants > one week of age demonstrate a consistent pattern of weight gain (typically about three days) via the current nutritional route;
 - 2. ≤ 7 % of birth weight lost in term infants < one week of age;
 - 3. ≤ 9 % of birth weight lost in late preterm (34 0/7 to 36 6/7 weeks of age) infants < one week of age.
- B. The nutritional product, **enteral** or intravenous, is appropriate for the nutritional needs of the infant and one of the following¹:
 - 1. The infant is on full oral nutrition;
 - 2. Home management of specialized nutrition needs, all of the following:
 - a. Caregiver and provider agree to home management;
 - b. Consultations (e.g. gastroenterology and nutrition) completed;
 - c. Appropriate feeding evaluation, family assessment and therapeutic interventions completed;
 - d. One of the following:
 - i. Gavage feeding for an infant **who is unable to take adequate oral feeds** and whose ongoing hospitalization is primarily for feeding support;
 - ii. Long-term gastrostomy tube feedings for infants with minimal oral intake or the inability ~~no ability~~ to feed orally, or the expectation of such to occur;
Note: Gastrostomy tube placement may be prior to NICU discharge or after a short-term trial of nasogastric (NG)/oral feeds at home;
 - iii. Intravenous (IV) total parenteral nutrition (TPN) as a nutritional source:
 - a) Infant has an inadequate ability to absorb calories **enterally**;
 - b) Fluid and electrolyte requirements have stabilized, as documented by the physician.¹²

II. Ability to maintain normal body temperature in a home environment

- A. Infant demonstrates the ability to maintain normal body temperature (36.5 to 37.5° C axillary or 36.6 to 38.0° C rectal) while clothed in an open bed/crib with normal ambient temperature (20 to 25° C) for 24 to 48 hours after removing thermal support (e.g. radiant warmer, isolette).⁵

Note: Weaning from an isolette should be considered when an infant in a stable cardiopulmonary state reaches > 1600 to 1800 grams and is able to be swaddled.¹¹

III. Mature respiratory control, one of the following:

- A. Infant is stable on room air;
- B. Infant is stable but has ongoing respiratory needs requiring additional support, all of the following:
1. Caregiver and physician agree to home management;
 2. Appropriate consultations and home equipment arrangements made;
 3. Infant has one or more of the following conditions:
 - a. Chronic Lung Disease (CLD)/Bronchopulmonary dysplasia (BPD) and 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:
 - i. Ventilator settings are stable and fraction of inspired O₂ is $\leq 40\%$ utilizing a home ventilator;
Note: May need to demonstrate up to seven days of stability on their home ventilator in the hospital prior to discharge.
 - ii. Home nursing support is arranged;
 - c. Ongoing medical conditions that increase risk for apnea, airway obstruction, or hypoxia and both of the following:
 - i. Assessment completed to determine which type of home monitoring system is appropriate (pulse oximetry monitor, cardiorespiratory monitor);
 - ii. Caregiver training in infant CPR.

Note: For guidelines for discharge of infants with apnea of prematurity, reference *CP.MP.82 NICU Apnea Bradycardia Guidelines*.

IV. Bilirubin levels are acceptable based on hours of life and risk factors (reference relevant nationally recognized clinical decision support criteria, and/or *CP.MP.150 Home Phototherapy for Neonatal Hyperbilirubinemia*).

V. Free of infection, or caregiver and physician agree to home antibiotics, for example, prophylactic antibiotics for urinary reflux.

Note: Reference *CP.MP.85 Neonatal Sepsis Management Guidelines*.

VI. Caregiver competency, evidenced by one of the following:

- A. Physician/nurse attestation or documentation;
- B. Successful room-in with parents/caregiver for one to two days.

Authorization Protocol

A. As an infant stabilizes, a lower level of care is appropriate for addressing medical needs. If there are no significant medical issues necessitating continued stay in Level I, II, III or IV nursery, the transitional care nursery level should be approved for any of the following.

1. Completion of an approved duration of antibiotic treatment;
2. Weaning of O₂ for a BPD infant or periodic O₂ needed for a infant that is progressing toward discharge on room air, as supported by physician documentation;
3. Tube feeding < 50% of daily caloric requirement and progressing toward discharge on all oral feedings as supported by physician documentation;
Note: Short term home NG feedings should be considered particularly when the infant is term or near-term gestation;
4. Apnea or bradycardia monitoring with a new significant episode in the last five to seven days and not planning to go home on a monitor;
5. Apnea or bradycardia monitoring with last dose of caffeine at least seven days prior to discharge.

Notes:

- Reference *CP.MP.82 NICU Apnea Bradycardia Guidelines* for treatment guidelines for infant apnea and bradycardia.
- Reference *CP.MP.86 NAS Guidelines for drug withdrawal treatment* for concerns of drug withdrawal.
- Reference *CP.MP.85 Neonatal Sepsis Management Guidelines* for treatment of infection.

B. Review for Level I or transitional care nursery days for social reasons including any of the following:

Note: These days may be denied as not medically necessary if Benefit Plan Contract does not include coverage for social days as medically necessary.

1. Discharge teaching;
2. Awaiting foster placement;
3. Inappropriate maternal behavior/poor bonding;
4. Parent/caregiver refusal to sign for medically indicated surgical procedures (e.g., tracheostomy or gastric tube);
5. Unsafe home environment or maternal lengthened postpartum course, illness or disability must be sent to the medical director for review.

C. Care may not be denied for any of the following:

1. No safe plan of care at home:
 - a. **Absence of**, or inadequate professional home care, when necessary;
 - b. **Absence** of necessary equipment for use at home (e.g. no home ventilator);
2. Lack of a parent/caregiver identified.

Note: Parent discharge teaching should occur during the process of achieving medical stability and should be completed by the time the medical stability is reached, rather than started after. Rooming-in for additional days after medical stability may be needed to

ensure parental/caregiver competency, depending on the complexity of the infant's condition.

NICU Discharge Recommended Practices

- A. Verify all of the following before discharge:
 - 1. The home/foster care environment is deemed safe and accessible;
 - 2. The parent or caregiver demonstrates the ability to manage the care of the infant;
 - 3. Follow-up care planned and communicated **with** caregivers and providers;
 - 4. Medications reconciled;
 - 5. Transportation needs identified and addressed;
 - 6. In cases of foster care placement, case worker contact information should be identified. The case worker should be involved and kept updated regarding discharge plans.
- B. Screening Tests:
 - 1. State-mandated metabolic screening testing should be completed;
 - 2. Screening for retinopathy of prematurity per AAP guidelines should be performed (or arranged as outpatient) with an ophthalmologist skilled in the evaluation of the retina of the preterm infant, with adequate follow-up for infants with active disease;
 - 3. Hearing screening should be completed prior to discharge with follow-up plans for infants requiring a full audiology assessment;
 - 4. An assessment of cardiorespiratory stability in a car seat or car bed is recommended prior to discharge for infants born at < 37 weeks gestation or for infants with other risk factors for cardiorespiratory compromise.
- C. Immunizations
 - 1. Infants should receive appropriate immunizations per CDC guidelines before discharge (or arranged as an outpatient) based on their postnatal age;
 - 2. **Specialized immunizations, when indicated (e.g., respiratory syncytial virus prophylaxis, including monoclonal antibody therapy and maternal vaccination strategies) should be administered or verified prior to discharge;**
 - 3. **Every effort should be made to ensure that parents and caretakers have been immunized against pertussis and influenza;**
- D. All parent(s)/caregiver(s) should be encouraged to attend infant CPR class or a hospital developed parent/caregiver education program prior to discharge.
- E. Car seats:
 - 1. All preterm infants less than 37 weeks should be tested for cardiorespiratory compromise prior to discharge. If the infant fails, use of a car bed should be considered. A similar period of cardiorespiratory monitoring in a car bed should be performed prior to discharge home;
 - 2. Must meet current safety standards and not exceed the expiration date;
 - 3. Must be adjusted to the infant's size **and meet manufacturer minimum weight limits;**
 - 4. Parents/caregivers educated on proper car seat fitting and use.



Background:

Nutritional competency

Weight alone should not be a criterion for discharge. Early hospital discharge is safe and feasible for low birth weight infants when behavioral and parental criteria, rather than achieved weight,

CLINICAL POLICY

NICU Discharge Guidelines

serve as discharge indicators.¹ Term infants often have a 5 to 7% weight loss in the first week of life with an expectation that they will be back to birth weight by 10 to 14 days of age.

Respiratory Control

Preterm infants typically demonstrate mature respiratory control by 36 to 37 weeks postmenstrual age. Occasionally, maturation of respiratory control can be delayed to up to 44 weeks.

Home oxygen therapy for infants with bronchopulmonary dysplasia has been used safely to achieve earlier hospital discharge. According to the Canadian pediatric society, some infants with prolonged oxygen dependency may be candidates for home oxygen therapy.⁷ In making decisions about home oxygen, each family's needs should be considered individually, balancing the burden of prolonged hospitalization with the impact of caring for an infant on home oxygen.⁷

Cardiorespiratory monitoring is indicated when an infant has an ongoing medical condition that increases risk for apnea, airway obstruction, or hypoxemia.⁹ Examples of conditions requiring home cardiorespiratory monitoring include, but are not limited to, the following:

- Pharmacological treatment of respiratory immaturity or continued apnea at term or near-term gestation (apnea of prematurity or apnea of infancy)
- Chronic lung disease (e.g., bronchopulmonary dysplasia), especially those requiring supplemental oxygen, positive airway pressure, or mechanical ventilatory support
- Congenital myasthenic syndromes
- Tracheostomy or other airway abnormalities.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed and reviewed by Neonatologist	04/13	06/13
Annual Review. Description updated with no impact on criteria. Criteria II.A. updated to include normal axillary and rectal temperature ranges and to include range for normal ambient environment temperature. References reviewed and updated.	06/22	06/22
Annual review. Updated the note in section II. from "1800 grams" to "1600 to 1800 grams." References reviewed and updated. Reviewed by external specialist.	02/23	02/23
Annual review. References reviewed and updated.	01/24	01/24
Annual review. Updated Authorization protocol A.5. Apnea or bradycardia monitoring with last dose of caffeine at least seven days prior to discharge. Updated NICU DC recommended practices B.4. An assessment of cardiorespiratory stability in a car seat or car bed is recommended prior to discharge for infants born at < 37 weeks gestation or for infants with other risk factors for cardiorespiratory compromise (e.g. neuromuscular, orthopedic problems). Updated E.1. to reflect car bed recommendations. Reference reviewed and updated. External specialist review.	01/25	01/25

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review. Updated normal ambient temperature range in Criteria II.A. Updated titles of policies in notes under Criteria III. and Criteria IV. with no impact to criteria. References reviewed and updated.	06/25	06/25
Annual review. Under I.B. replaced “enteric” with “enteral”. I.B.2.d.i. replaced “who cannot feed well...” with “who is unable to take adequate...”. I.B.2.d.ii. reworded with no impact on criteria and moved note to a separate line. In Note under I.B.2.d.ii. removed “gastrostomy tube placement...” I.B.2.d.iii. removed “(short gut)” and added “enterally”. Under Authorization Protocol, B. reworded with no impact on criteria and moved “These days may be denied...” below section to improve flow. Under Authorization Protocol, C.1.a. replaced “No” with “Absence of”. Under C.1.b. replaced “Lack” with “Absence”. Under C.2. reworded Note with no impact on criteria. Under NICU Discharge Recommended Practices, A.3. replaced “between” with “with”. Under C.2. removed “immunoglobulin” and added “including monoclonal...” and “verified”. Under C.3. replaced “assure” with “ensure”, added “and influenza” and removed “with the Tdap...”. Under E.3. added “and meet manufacturer...”. Removed E.5. “Four pound (1815 gram) car seat...”. Background updated with no impact on criteria. Reviewed by internal and external specialists.	06/26	06/26

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering

CLINICAL POLICY

NICU Discharge Guidelines

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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CLINICAL POLICY

NICU Discharge Guidelines



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