I. Policy: Home Health and DME Related to Hyperbilirubinemia

II. Purpose/Objective:
To provide a policy of coverage regarding Home Health and DME Related to Hyperbilirubinemia

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;

b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;

c. in accordance with current standards of good medical treatment practiced by the general medical community.

d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and

e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

**ALL Durable Medical Equipment** provided for home use requires advanced determination of coverage. Devices furnished at inpatient or outpatient centers are **NOT SEPARATELY REIMBURSABLE**. Progressive stretch device must be obtained through a participating Durable Medical Equipment Vendor(s).

**DESCRIPTION:**
Home phototherapy for neonatal jaundice is a treatment that involves continually applying ultraviolet light by means of a lamp to an infant in the home for a prescribed period of time. Application of the ultraviolet light helps reduce elevated bilirubin levels.

**INDICATIONS:** Home phototherapy treatment for the diagnosis of **physiologic jaundice of the term newborn** is considered appropriate when the following criteria are met.

- Total bilirubin level must be greater than 12 mg/dL and less than 22 mg/dL*; and
- The infant is otherwise healthy, active and feeding well
- Caregivers are capable of understanding and following direction

**NOTE:** Requests for home phototherapy for diagnoses other than physiologic jaundice of the term newborn, or when bilirubin levels are outside of the indicated levels, should be reviewed with a Plan medical director

![Graph](image)  
**Fig 3.** Guidelines for phototherapy in hospitalized infants of 35 or more weeks’ gestation. (Academy of Pediatrics Clinical Guideline, Pediatrics 114(1), 2004.)

<table>
<thead>
<tr>
<th>Age (hours)</th>
<th>Consider phototherapy</th>
<th>Phototherapy</th>
<th>Stop</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-48</td>
<td>≥ 12 mg/dL</td>
<td>≥ 15 mg/dL</td>
<td>≤ 8 mg/dL</td>
</tr>
<tr>
<td>49-72</td>
<td>≥ 15 mg/dL</td>
<td>≥ 18 mg/dL</td>
<td>≤ 11 mg/dL</td>
</tr>
<tr>
<td>&gt;72</td>
<td>≥ 17 mg/dL</td>
<td>≥ 20 mg/dL</td>
<td>≤ 14 mg/dL</td>
</tr>
</tbody>
</table>

(*) based on American Academy of Pediatrics Recommendations and practice patterns and recommendation of Geisinger Health System physicians)

**PROCESS:**
Authorization for Home Health visits will be made by Medical Management

- In-home phototherapy must be ordered by a physician
Requests for home phototherapy outside the criteria of this policy should be reviewed with a Plan medical director.

Daily skilled nursing visits by a maternal child nurse will be authorized for assessment and heel stick lab draws for as long as phototherapy is maintained.

The Durable Medical Equipment (DME) provider will educate the caregivers in the use of equipment and initial set-up of the phototherapy unit. (Set up does not constitute a skilled visit)

HOME VISIT GUIDELINES:
- The nurse obtaining the specimen will be responsible to report lab findings to the ordering physician
- The nurse will follow assessment parameters for infant as defined in the early discharge program.

LIMITATIONS:
Specific limitations and/or exclusions as stated in the benefit document will supercede this policy. If applicable, limitations of the Durable Medical Equipment benefit will apply.

CODING ASSOCIATED WITH: Home Health and DME Related to Hyperbilirubinemia

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

E0202 Phototherapy (bilirubin) light with photometer
S9098 Home visit, phototherapy services (e.g., bili-lite), including equipment rental, nursing services, blood draw, supplies, and other services, per diem.
A4633 replacement bulb/lamp for ultraviolet light therapy system, each


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:


This policy will be revised as necessary and reviewed no less than annually.

Devised: 10/02 (Formerly HH 111)
Revised: 12/03 (definition), 2/05 (added graphic), 4/11 (added indication)
Reviewed: 2/06; 2/07; 2/08; 2/09; 3/10, 4/12, 4/13, 4/14, 4/15, 4/16, 3/17, 3/18, 3/19, 3/20