Home phototherapy for neonatal jaundice is a treatment that subjects a jaundiced infant to continuous light from a special lamp (phototherapy unit) for a prescribed period of time. Application of continuous phototherapy light helps reduce elevated bilirubin to acceptable levels. Successful phototherapy can prevent brain damage in an infant.

II. Criteria/Guidelines

Home phototherapy is covered (subject to the Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:

A. The infant is 37 weeks or more gestational age.

B. The infant is otherwise ready to be discharged from the hospital; and

C. The infant is active, alert and feeding well; and

D. Arrangements have been made to examine and evaluate the infant within 48 hours after discharge by a physician to monitor total serum bilirubin levels.

E. Total serum bilirubin at discharge or post-discharge must be monitored daily by a CLIA approved lab and fall within the levels listed below:

<table>
<thead>
<tr>
<th>Age</th>
<th>Total Serum Bilirubin (mg/dl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hours</td>
<td>8.5 – 11.5</td>
</tr>
<tr>
<td>36 hours</td>
<td>10.5 – 13.5</td>
</tr>
<tr>
<td>48 hours</td>
<td>12.0 – 15.0</td>
</tr>
<tr>
<td>60 hours</td>
<td>13.5 – 16.5</td>
</tr>
</tbody>
</table>
III. Limitations/Exclusions

A. The treating physician is responsible for ensuring the caregiver receives proper instructions relating to: infant care, use of home phototherapy, and follow-up treatment. These instructions must be in accordance with the American Academy of Pediatrics (AAP) guidelines.

B. Home phototherapy is not covered for infants with any of the following risk factors as specified in the AAP guidelines, including but not limited to:
   1. Isoimmune hemolytic anemia (e.g., Rh or ABO isoimmune hemolytic anemia)
   2. G6PD deficiency
   3. History of asphyxia
   4. Lethargy
   5. Temperature instability
   6. Infection, suspected or treated
   7. Acidosis

C. Home phototherapy is not covered for infants with a gestational age of less than 37 weeks.

D. Transcutaneous bilirubin determinations are not an acceptable monitoring alternative once phototherapy is initiated.

E. Phototherapy should be discontinued once the total serum bilirubin level has fallen below the age-specific range listed in the table above.

F. Refer to HMSA’s Home Health Care policy for eligibility requirements for home nursing care. Home nursing services, if applicable, is limited to the evaluation of the infant only, it does not include set up or retrieval of the phototherapy unit, or instructing the caregiver on its use.

IV. Administrative Guidelines

A. Precertification is not required.

B. The DME supplier is responsible for obtaining and keeping the following information in the patient's file:
   1. The physician orders
   2. Gestational age of the infant
   3. Date/time of birth
   4. Start/end dates of phototherapy services
   5. Daily total serum bilirubin levels through the phototherapy period, including date and time of collection.
C. Documentation of the caregiver's homebound status must be kept in the patient's medical file by the home health agency (if billing S9098).

D. HMSA may perform retrospective reviews to ensure that services rendered were appropriate and may request supporting documentation from the DME supplier.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0202</td>
<td>Phototherapy (bilirubin) light with photometer</td>
</tr>
<tr>
<td>S9098</td>
<td>Home visit, phototherapy services (e.g., bili-lite), including equipment rental, nursing services, blood draw, supplies, and other services, per diem</td>
</tr>
</tbody>
</table>

V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.
VI. References

