Home IV Hydration Therapy for Hyperemesis Gravidarum

I. Policy

University Health Alliance (UHA) will reimburse for home IV hydration therapy for hyperemesis gravidarum when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Description

Hyperemesis gravidarum is a condition in which pregnant women have severe, intractable vomiting that may result in significant weight loss, fluid volume deficit, starvation ketoacidosis, metabolic alkalosis, and hypokalemia.

Management strategies include hydration, antiemetic medications, and dietary management. Controlling the symptoms at an early stage prevents the development of progressive, excessive, and prolonged vomiting, which can present a serious threat to the nutritional status of the mother and ultimately affects the outcome of the pregnancy.

III. Criteria/Guidelines

A. Home IV hydration therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) for a patient who is diagnosed with hyperemesis gravidarum and has clinical evidence of hyperemesis gravidarum as follows:
   1. Persistent vomiting three or more times per 24 hours, and
   2. The patient has not responded to medical therapy OR the patient's weight loss is 5 percent or more of her pre-pregnancy weight, and
   3. The patient has two or more of the following diagnostic or laboratory values:
      a) Urine specific gravity greater than or equal to 1.030
      b) Positive acetone in urine
      c) Pulse greater than or equal to 100 beats per minute at rest
      d) Systolic blood pressure less than or equal to 100 mm Hg
      e) Blood urea nitrogen greater than or equal to 20 mg/dL
      f) Serum potassium less than or equal to 3.5 meq/L
      g) Serum sodium less than or equal to 135 meq/L
      h) Serum chloride less than or equal to 97 meq/L

B. Continuation of therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the patient's condition has not resolved or improved to the extent that the patient is able to tolerate adequate oral or enteral fluids.

C. The patient does not need to meet the definition of homebound to receive this therapy.
D. **NOTE:**

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

### IV. Limitations/Exclusions

A. Extension of therapy is not covered when:

1. The patient or caregiver is unwilling or unable to manage or continue with the home infusion program
2. The goals of therapy have been achieved (e.g., resolution of hypovolemia and/or electrolyte imbalance)
3. The patient or caregiver is noncompliant with treatment
4. Follow-up assessment of the patient's clinical progress is not performed
5. The patient has gained five percent or more of her pre-pregnancy weight
6. The patient is able to tolerate oral fluids greater than or equal to 1500 mL/24 hr and nutritional needs are met
7. Hospitalization is indicated in severe intractable vomiting with persistent weight loss unresponsive to outpatient IV hydration and antiemetics

### V. Administrative Guidelines

A. Prior authorization is not required when the above criteria are met.

B. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.

### VI. Policy History

- **Policy Number:** M-INF.05.120201
- **Current Effective Date:** 01/01/2017
- **Original Document Effective Date:** 02/01/2012
- **Previous Revision Dates:** 01/01/2017
- **PAP Approved:** 02/01/2012

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