Clinical Policy: Infant Apnea Monitors

Reference Number: GA.CP.MP.06
Last Review Date: 09/2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information

Description

Peach State Health Plan (PSHP) follows the Georgia Department of Community Health, Division of Medicaid, Durable Medical Equipment Services, Infant Apnea Monitors authorization guidelines. This clinical policy provides medical necessity guidelines for coverage of Infant Apnea Monitors.

Policy/Criteria

I. **Initiation of the Apnea Monitor**

It is the policy of Peach State Health Plan (PSHP) that the rental of an infant apnea monitors is **medically necessary** for infants whose medical record documents episode(s) of apnea and/or bradycardia that are considered to be apparent life-threatening events with at least one of the following indications:

A. Apnea accompanied by marked hypotonia
B. Gastrointestinal reflux resulting in apnea, bradycardia, or oxygen desaturation
C. Infants such as ex-premature infants at high risk of recurrent episodes of prolonged apnea with duration greater than 20 seconds, bradycardia (heart rate of less than 80 beats per minute) and hypoxemia (oxygen saturation below 90 percent) to start after hospital until the infant is event-free for six (6) weeks
D. Infants with chronic lung disease (i.e., Bronchopulmonary dysplasia), especially those requiring the use of oxygen, CPAP, or mechanical ventilation
E. Infants with tracheostomies or anatomic abnormalities that compromise the airway
F. Respiratory Syncytial Virus (RSV)
G. Sibling of an infant that died as a result of Sudden Infant Death Syndrome (SIDS)
H. Whooping cough (includes Pertussis)

II. **Duration of infant apnea monitor rental**

A. PSHP will reimburse the initial request for the infant apnea monitor for a maximum duration of four (4) rental months for an infant up to one (1) year of age.
B. Children with tracheotomies will be eligible for an extended coverage period for rentals of the apnea monitor for up to twenty (20) additional months (two (2) years total) if it is still considered medically necessary by the treating physician at three (3) month intervals at which time the prior authorization must be renewed.

III. **Continuation of the infant apnea monitor rental**

A. Prior authorization requests for an extended rental period must include the following attachments:
   1. A certificate of medical necessity (CMN) indicating the extended time period requested (no more than three (3) months permitted) with specific medical documentation that supports the continuation of medical necessity, AND
   2. A one (1) page download summary from the physician indicating the continued

apnea or bradycardia events. The summary must be signed and dated by the physician.

B. Requests for extension of coverage will be approved at a maximum of three (3) months intervals.
C. Additional information may be requested, e.g., (sleep study for members over one (1) year of age, etc.) in order to make a determination that the device is still medically necessary.
D. PSHP will only reimburse monitors that record and document in real time.
E. The provider must download the apnea monitor results and send the report to the ordering physician who prescribed use of the monitor for review and signature before the device can be recertified for an extended rental period.
F. The provider must check for member compliance through necessary home visits and the use of telephone modem.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
E0619	Apnea Monitor, with recording feature

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	11/2015	11/2015
Updated References	10/2016	10/2016
Added All next to PRODUCT TYPE: All Minor reformatting throughout the document. I. Added Coding Guidelines: E0619-Apnea Monitor, with recording feature. Apnea monitors are only reimbursed as a monthly rental (RR). Under II.A. g added “to start” after hospital discharge to clarify the sentence. Updated References.	09/2018	09/2018
Converted to new Centene Corporation clinical policy template with minor reformatting throughout. Updated References.	08/2019	09/2019
Changed policy title from “Medical Necessity for Infant Apnea Monitors” to “Infant Apnea Monitors”. Updated the **Description**. Reference number changed from GA.MP.06 to GA.CP.MP.06 per the Centene State-Specific Clinical Policy Process: CP.CPC.04. Updated References.	09/2020	09/2020

Reviews, Revisions, and Approvals	Date	Approval Date
Updated References	09/2021	09/2021

References

1. Part II Policies and Procedures for Durable Medical Equipment Services. Georgia Department of Community Health, Division of Medical Assistance Plans. Policy 1112.1 Apnea Monitors (Infant). 04/13; 07/13; 11/13; 10/14; 04/15; 10/16; 07/17; 07/18; 04/19; 07/19; 07/2020; 07/2021.

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 benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, 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, 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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