Priority Health	BILLING POLICY No. 187
APNEA MONITORS	
Date of origin: April 2026	Review dates: None yet recorded

DEFINITION

A home apnea monitor is a machine used to monitor a baby's heart rate and breathing after coming home from the hospital. Apnea is breathing that slows down or stops from any cause. An alarm on the monitor goes off when the baby's heart rate or breathing slows or stops. The monitor is small and portable. A monitor may be needed in certain circumstances where the infant is at risk for apneic episodes.

MEDICAL POLICY

Durable Medical Equipment # 91110

POLICY SPECIFIC INFORMATION

Apnea monitors may be allowed for the following conditions:

A newborn infant (defined as first 28 days or 4 weeks of life) following hospital discharge with a condition that may put them at risk for apneic episodes. Examples may include:

1. Apnea of prematurity
2. High-risk Brief Resolved Unexplained Event (BRUE)
3. Tracheostomy or airway abnormalities
4. Neurologic or metabolic disorders affecting respiratory control
5. Chronic lung disease

Apnea monitors are DME capped rental. Capped rental means monthly payments for the use of the Durable Medical Equipment (DME) for a limited period not to exceed 13 months.

Please see our Durable Medical Equipment (DME) Capped Rental Billing policy for more information.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

DME claims should be coded with the POS where the member will primarily use the DME item.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Coding specifics

CPT/HCPCS codes

E0619 Apnea monitor, with recording feature

Not Medically Necessary
E0618 Apnea monitor, without recording feature

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Capped Rental modifiers

- KH: First Month: KH is used for the initial claim or the first month of the capped rental period.
- KI: Second and Third Months: KI is used for the second and third months of the capped rental.
- KJ: Months 4-13: KJ is used for months four through thirteen of the capped rental period.
- NU: New
- RR: Rental

Resources

Related policies
Billing policy No. 110 Durable Medical Equipment (DME) Capped Rental

Billing policy No. 050 Durable Medical Equipment (DME) Place of Service (POS)

Billing Policy No. 108 Durable Medical Equipment (DME) Repair and Replacement

Billing Policy No. 022 General Coding

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
April 2026	New policy