Priority Health

MEDICAL POLICY
No. 91497-R3

APNEA MONITORS

Effective Date: February 26, 2015	**Review Dates: 1/05, 12/05, 12/06, 12/07, 12/08, 12/09, 12/10, 12/11, 12/12, 12/13, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22, 2/23, 2/24, 5/24, 5/25**
Date Of Origin: January 19, 2005	**Status: Current**

I. POLICY/CRITERIA

Priority Health considers apnea monitors medically necessary for **any** of the following conditions:

A. A newborn infant following hospital discharge with one or more of the following conditions:

1. Apnea of newborn
2. Apnea of prematurity
3. Apparent life threatening event (ALTE)
4. Bronchopulmonary dysplasia

B. An acute respiratory illness in infants:

- Units are covered for a respiratory illness/diagnosis such as Pertussis, Respiratory Syncytial Virus (RSV), or pneumonia.

C. As a diagnostic tool:

- Units are covered as a diagnostic tool if the infant is under three months of age at set up, and the parent and/or guardian reports suspected events.

D. Monitors are considered medically necessary for infants with tracheostomy or those needing continuous positive airway pressure.

E. Medicaid members

Any member who is an adult and requiring an apnea monitor **must** be in active case management. Any child with a monitor **must** have an evaluation for Children's Special Health Care Services (CSHCS) referral and should be evaluated for case management.

F. Apnea monitors are generally considered not medically necessary for the following diagnoses/medical conditions unless documentation justifies medical necessity:

1. Chromosomal abnormalities
2. Congenital heart defects with or without arrhythmias
3. Cerebral palsy
4. Asymptomatic prematurity
5. Developmental delay/mental retardation
6. Seizure disorder
7. Hydrocephaly with or without Arnold Chiari Syndrome
8. Irreversible terminal conditions
9. Family history of SIDS
10. SIDS prevention

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***

- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. DESCRIPTION

Apnea monitors for infants may be considered medically necessary as described in this policy.

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 when:

- A baby has ongoing apnea
- A baby has severe reflux
- A baby needs to be on oxygen or a breathing machine

How long a baby stays on the monitor depends on how often real alarms go off. Real alarms mean the baby does not have a steady heart rate or is having trouble breathing. Babies typically wear a home apnea monitor for 2 to 3 months.

Home monitors are frequently used in the NICU [neonatal intensive care unit] setting to allow for earlier discharge of infants with mild, persistent apnea of prematurity. However, they have not been found to be protective against SUID [sudden unexpected infant death] and are not recommended for this purpose. In addition, the use of non–medical-grade monitors has increased in popularity. As per task force recommendations, parents should be educated that no monitor takes the place of following the safe sleep recommendations (Goodstein et al., 2021).

The following is the recommendation from the American Academy of Pediatrics (AAP) regarding use of home cardiorespiratory monitors, including apnea monitors, as a strategy to reduce the risk of SIDS [sudden infant death syndrome] (Moon et al. 2022):

> **Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SIDS. Use of cardiorespiratory monitors has not been documented to decrease the incidence of SIDS**. These devices are sometimes prescribed for

use at home to detect apnea, bradycardia, and, when pulse oximetry is used, decreases in oxyhemoglobin saturation for infants at risk for these conditions, including some preterm infants with an unusually prolonged course of recurrent, extreme apnea. In addition, routine, in-hospital cardiorespiratory monitoring before discharge from the hospital has not been shown to detect infants at risk for SIDS. Direct-to-consumer heart rate and pulse oximetry monitoring devices, including wearable monitors, are sold as consumer wellness devices. A consumer wellness device is defined by the FDA as one intended "for maintaining or encouraging a healthy lifestyle and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition." Thus, these devices are not required to meet the same regulatory requirements as medical devices and, by the nature of their FDA designation, are not to be used to prevent sleep-related deaths. Although use of these monitors may give parents "peace of mind," and there is no contraindication to using these monitors, data are lacking to support their use to reduce the risk of these deaths. There is also concern that use of these monitors will lead to parent complacency and decreased adherence to safe sleep guidelines. A family's decision to use monitors at home should not be considered a substitute for following AAP safe sleep guidelines.

V. CODING INFORMATION

ICD-10 Codes that <u>may</u> support medical necessity:

A37.00 – A37.91	Whooping cough
B77.81	Ascariasis pneumonia
B97.4	Respiratory syncytial virus as the cause of diseases classified elsewhere
J12.0 – J12.9	Viral pneumonia not elsewhere classified
J15.0-J15.9	Bacterial Pneumonia
J16.0-J16.8	Pneumonia due to other infectious organisms not elsewhere classified
J17	Pneumonia in diseases classified elsewhere
J18.0-J18.9	Bronchopneumonia
J20.5	Acute bronchitis due to respiratory syncytial virus
J21.0 – J21.9	Acute bronchiolitis
J80	Acute respiratory distress syndrome
J95.1	Acute pulmonary insufficiency following thoracic surgery
J95.2	Acute pulmonary insufficiency following nonthoracic surgery
J95.3	Chronic pulmonary insufficiency following surgery
J95.821	Acute post procedural respiratory failure
J95.822	Acute and chronic post procedural respiratory failure
J96.00 – J96.92	Respiratory failure, not elsewhere classified
J98.4	Other disorders of lung
P07.00 – P07.39	Disorders of newborn related to short gestation and low birth weight, not elsewhere classified
P22.0 – P22.9	Respiratory distress of newborn
P23.0 – P23.9	Congenital pneumonia
P24.01	Meconium aspiration with respiratory symptoms
P24.11	Neonatal aspiration of (clear) amniotic fluid and mucus with respiratory symptoms
P24.21	Neonatal aspiration of blood with respiratory symptoms
P24.81	Other neonatal aspiration with respiratory symptoms
P24.9	Neonatal aspiration, unspecified
P27.0 – P27.9	Chronic respiratory disease originating in the perinatal period
P28.0 – P28.9	Other respiratory conditions originating in the perinatal period
P84	Other problems with newborn
Q31.0 – Q31.9	Congenital malformations of larynx
Q32.0 – Q32.4	Congenital malformations of trachea and bronchus
R06.00	Dyspnea, unspecified
R06.09	Other forms of dyspnea
R06.3	Periodic breathing
R06.89	Other abnormalities of breathing
R68.13	Apparent life threatening event in infant (ALTE)

Z93.0 Tracheostomy status

CPT/HCPCS Codes
E0619 Apnea monitor, with recording feature

Not Covered:
E0618 Apnea monitor, without recording feature

VI. REFERENCES

1. A.D.A.M. Medical Encyclopedia [Internet]. Johns Creek (GA): Ebix, Inc., A.D.A.M.; c1997-2020. Home apnea monitor use - infants; [reviewed 2023 Jul 01]. Available from: https://medlineplus.gov/ency/patientinstructions/000755.htm
2. Eichenwald EC and AAP COMMITTEE ON FETUS AND NEWBORN. Apnea of Prematurity. Pediatrics. 2016;137(1):e20153757
3. Erickson CC, Salerno JC, Berger S, et al; AAP SECTION ON CARDIOLOGY AND CARDIAC SURGERY, PEDIATRIC AND CONGENITAL ELECTROPHYSIOLOGY SOCIETY (PACES) TASK FORCE ON PREVENTION OF SUDDEN DEATH IN THE YOUNG. Sudden Death in the Young: Information for the Primary Care Provider. Pediatrics. 2021;148(1):e2021052044
4. Goodstein MH, Stewart DL, Keels EL, et al; AAP COMMITTEE ON FETUS AND NEWBORN, TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. Transition to a Safe Home Sleep Environment for the NICU Patient. Pediatrics. 2021;148(1):e2021052045
5. Goodstein M H, Stewart D L, Keels E L, et al. AAP COMMITTEE ON FETUS AND NEWBORN, TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. Transition to a Safe Home Sleep Environment for the NICU Patient. Pediatrics. 2021;148(1):e2021052046
6. Moon RY, Carlin RF, Hand I; AAP Task Force on Sudden Infant Death Syndrome; AAP Committee on Fetus and Newborn. Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics. 2022;150(1):e2022057990
7. National Institute of Child Health and Human Development (NICHD). Safe to Sleep. n.d.; https://www1.nichd.nih.gov/sts/Pages/default.aspx

agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion.

Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

The name "Priority Health" and the term "plan" mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.