Apnea Monitors

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury, or improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" is defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines, and certificates of coverage for possible exclusions of benefits.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification, as applicable.

All apnea monitors require precertification and physician face-to-face.

National Coverage Determination Policy	None
Local Coverage Determination Policy	None
Policy Effective Date	09/01/10
Policy Review/Revision Date	01/2019, 10/2018, 5/2018, 04/01/2017, 02/15/2016, 05/01/2014
The Health Plan	All Plans will follow The Health Plan policy

DESCRIPTION

Apnea monitors are considered medically necessary durable medical equipment (DME) for infants less than 12 months of age with documented apnea, or who have known risk factors for life-threatening apnea, according to the following indications: apnea is defined as an unexplained episode of cessation of breathing for 20 seconds or longer, or a shorter respiratory pause associated with bradycardia, cyanosis, pallor, or marked hypotinia.

COVERAGE GUIDELINES

1. Prolonged apnea of greater than 20 seconds in duration.
2. Diagnosis of pertussis, **confirmed by positive cultures**. If monitored for pertussis, use of an apnea monitor is considered medically necessary for up to one month post diagnosis, unless new updated information is submitted.
3. Apnea accompanied by bradycardia.
4. Apnea accompanied by oxygen desaturation (oxygen saturation below 90 percent).
5. Metabolic disorders (i.e., gastroesophageal reflux disease (GERD)) affecting respiratory control and involving any of the above symptoms (1-4).
6. Infants with an apparent life-threatening event (ALTE), defined as an episode that is characterized by some combination of: central or obstructive sleep apnea, pallor or cyanosis, erythematous, or plethoric, marked change in muscle tone, limpness or hyptonic, choking, or gagging.
7. Infants with bradycardia on caffeine, theophylline, or similar agents, until event free for six weeks off the medication.
8. Infants with chronic lung disease (bronchopulmonary dysplasia), especially those requiring supplemental oxygen, continuous positive airway pressure, or mechanical ventilation.
9. Infants with neurologic disorders (medical necessity reviewed on an individual case basis).
10. Infants with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise (medical necessity reviewed on an individual case basis).

For indications 1-6, an apnea monitor is covered until the infant remains event free for six weeks. For use greater than three months, it will be determined on a case-by-case basis.

Continued use of an apnea monitor may be considered medically necessary, when infants become 1 year old, if criteria is met. These requests will be reviewed on a case-by-case basis.

NONCOVERAGE STATEMENT

West Virginia Medicaid does not cover the apnea monitor, code E0618, for individual home use.

The Health Plan does not cover apnea monitor, code E0618.

The Health Plan does not cover an apnea monitor in the home setting for the prevention of sudden infant death syndrome, as it is considered experimental, investigational, with unproven efficacy.

CODING INFORMATION

HCPCS CODES COVERED IF SELECTION CRITERIA ARE MET:

A4556	**ELECTRODES (E.G., APNEA MONITOR), PER PAIR**
A4557	**LEAD WIRES (E.G., APNEA MONITOR) PER PAIR**
E0619	**APNEA MONITOR, WITH RECORDING FEATURES**

The Health Plan covers apnea monitor (E0619) for use in the home setting. Reimbursement is based on Mountain Health Trust (MHT) rates, as there is no Medicare rate.

A4556 is not separately billable with the apnea monitor, included in the rental of monitor.

A4557 is not separately billable with the apnea monitor, included in the rental of monitor.

REPAIR, REPLACEMENT, AND REASONABLE USEFUL LIFETIME

Replacement or repair of the device during the rental period is the responsibility of the provider.

West Virginia Medicaid allows 1, Apnea monitor (E0619) per lifetime. THP will review if there are extenuating circumstances.

Reasonable useful lifetime for other lines of business is 5 years or manufactures warrenty.

Replacement due to loss, significant change in the member's condition, or irreparable accidental damage, natural disaster, or burglary is covered, if the item is still medically necessary. The reason for the replacement must be provided with the precertification or claim submission if no precertification is required.

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY

ICD-10 codes covered if selection criteria is met (not all-inclusive):

A37.00-A37.90	**WHOOPING COUGH**
G93.1	**ANOXIC BRAIN DAMAGE**
I49.5-R00.1	**SINOATRIAL NODE DYSFUNCTION**
I49.8-R00.1	**OTHER SPECIFIED CARDIAC DYSRHYTHMIA**
K21.9	**ESOPHAGEAL REFLUX**
Q30.0-Q34.8	**CONGENITAL ANOMALIES OF RESPIRATORY SYSTEM**
Q39.0-Q39.4	**TRACHEOESOPHAGEAL FISTULA, ESOPHAGEAL ATRESIA AND STENOSIS**
Q39.5-Q39.6	**OTHER SPECIFIED ANOMALIES OF ESOPHAGUS**
P07.00-P07.30	**EXTREME IMMATURITY , OTHER PRETERM INFANTS**
P07.21-P07.37	**WEEKS OF GESTATION 24 OR LESS COMPLETED**
P22.0	**RESPIRATORY DISTRESS SYNDROME**
P23.9-P28.89	**OTHER RESPIRATORY CONDITIONS OF FETUS AND NEWBORN**
P29.12	**NEONATAL BRADYCARDIA**
R23.0	**CYANOSIS**
R23.1	**PALLOR**

R06.81	**APNEA**
Z93.0	**TRACHEOSTOMY STATUS**
Z99.11	**DEPENDENCE ON RESPIRATOR**
Z99.81	**DEPENDENCE ON SUPPLEMENTAL OXYGEN**

Diagnoses and ICD-10 codes that either support or do not support medical necessity are listed above.
NOTE: The ICD-10 code that justifies the need for these items must be included on the claim.

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
    a. Member's name
    b. Date
    c. Description of item. The medical record must contain the information that supports the request for each item and must be submitted with the precertification if the item requires precertification, or with the claim, if no precertification was required
    d. Order must include diagnosis code
    e. Physician signature with date. Date stamps are not appropriate
    f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

       The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request usually with precertification per Health Plan policy.

Proof of delivery to be kept on file by the provider of the item.

Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), and all of the required information is not included, The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

Note: Template provider forms, prescriptions, and attestation letters are not considered part of

APNEA MONITOR PROVIDED WHILE MEMBER IN PART A FACILITY

Reimbursement for a Apnea monitor provided to a member while the member is covered in a Part A facility is based on specific contract information with the individual facility, and whether or not the device is intended for use while the member is in the facility.

An Apnea Monitor should not be billed under DME benefit while in an acute hospital stay.

EQUIPMENT RETAINED FROM A PRIOR PAYOR:

The Health Plan will not pay in excess of the contracted purchase price for any item in this policy. If the provider is seeking payment from The Health Plan, the item must be precerted and The Health Plan will pay the remaining rental months up to purchase price- if member meets guidelines above.

BILLING GUIDELINES

Ther are no unique billing guidelines for Apnea Monitors. It is a capped rental item.

Supplies cannot be separately billed during rental month. See The Health Plan Compensation Guide for Quantity limits

KX, GA, AND GZ MODIFIERS

Suppliers may submit a claim with a KX modifier only if all the criteria for that item is met.

If coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier, if they have not obtained a valid ABN.

ADVANCED BENEFICIARY STATEMENT

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

NOTE: Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. dmepdac.com/

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INTERNET LINKS AND SOURCES

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