ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Planning & Development

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TO: **Arkansas Medicaid Health Care Providers – Prosthetics**

DATE: **March 1, 2010**

SUBJECT: **Provider Manual Update Transmittal #70**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
212.201	4-1-09	212.201	3-1-10

Explanation of Updates

Section 212.201 is being revised. Providers are being advised that prior authorization for the use of the apnea monitor is not required for the initial sixty-day period. New criteria for use of the monitor are being added.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-8323 (Local); 1-800-482-5850, extension 2-8323 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

TOC not required

212.201 (DME) Apnea Monitors for Infants Under Age 1 3-1-10

Arkansas Medicaid covers apnea monitors only for infants less than one (1) year of age. Use of the apnea monitor must be medically necessary and prescribed by a physician.

A primary care physician (PCP) is not required until an infant's Medicaid eligibility has been determined. No PCP referral for medical services is required for retroactive eligibility periods.

For the initial certification, the prescribing physician must sign form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The physician's signature must be an original, not a stamp. When an apnea monitor is prescribed during a hospital discharge, the physician ordering the apnea monitor must be in consultation with a neonatologist or pulmonologist.

As necessary, the primary care physician's (PCP's) name and provider number must also be indicated on DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. The PCP's signature is not required on the initial certification but he or she must sign all re-certifications.

A prior authorization request for an apnea monitor must be submitted to AFMC on form DMS-679A titled Prescription and Prior Authorization Request for Medical Equipment Excluding Wheelchairs and Wheelchair Components. **View or print form DMS-679 and instructions for completion.** **View or print AFMC contact information.**

Compliance, and the download monitor report, must accompany the request for continued use of the apnea monitor following the initial sixty-day time period.

Prior authorization is not required for the initial sixty-day period of use of the monitor. If the apnea monitor is needed longer than an initial sixty-day period, prior authorization is required.

A new prescription, documentation of compliance during the initial sixty-day period and proof of medical necessity for the continuation of monitoring are required.

The following criteria, established by the *American Academy of Pediatrics*, are to be used to evaluate the need for an apnea monitor after the initial sixty-day period:

A. Evidence exists that preterm infants are at greater risk of extreme apnea episodes until approximately 43 weeks post conceptual age. Monitoring may be indicated until 43 weeks post conceptual age unless extreme episodes persist beyond that time. Home monitoring may be indicated for other selected groups of infants, as well.

B. Home cardiorespiratory monitoring may be warranted for premature infants who are at high risk of recurrent episodes of apnea, bradycardia, and hypoxemia after hospital discharge.

   The use of home cardiorespiratory monitoring in this population should be limited to approximately 43 weeks post conceptual age or after the cessation of extreme episodes, whichever comes last.

C. Home cardiorespiratory monitoring may be warranted for infants who are technology dependent (tracheostomy, supplemental oxygen, continuous positive airway pressure, etc.), have unstable airways, have rare medical conditions affecting regulation of breathing or have symptomatic chronic lung disease.

In many of these cases, the use of pulse oximetry monitoring is superior and preferred over simple cardiorespiratory monitoring.

D. Other infants who may benefit from home cardiorespiratory home monitoring include:

1. Infants who have experienced an apparent life-threatening event (ALTE)

   An ALTE is defined as “an episode that is frightening to the observer and is characterized by some combination of apnea (central or occasionally obstructive), color change (usually cyanotic or pallid but occasionally erythematous or plethoric), marked change in muscle tone (usually marked limpness), choking or gagging.”

2. Infants with tracheotomies or anatomic abnormalities that may compromise their airway
3. Infants with metabolic or neurological abnormalities affecting respiratory control
4. Infants with chronic lung disease of prematurity (bronchopulmonary dysplasia, BPD), especially those requiring some form of respiratory support

E. Parents or caregivers must be counseled regarding the purpose of the home cardiorespiratory monitoring and realistic expectations of what it can and cannot contribute to an infant’s well being.

1. When monitoring is used in the home, parents and other caregivers must be trained in observation techniques, operation of the monitor, and infant cardiopulmonary resuscitation prior to the use of the monitor.
2. Medical and technical support staff should always be available for direct or telephone consultation.

F. Duration and discontinuation of home cardiorespiratory monitoring

1. When home monitoring is prescribed for apnea/bradycardia in preterm infants, the physician should establish a plan for review of clinical and event (download) data at 43 weeks post conceptual age. If monitoring is to be continued beyond that time, documentation should be provided as to why it should be continued as well as a plan for reevaluation.
2. Infants whose mothers have unsure dates (uncertain post-conceptual age) may be monitored until the infants are at least 43 weeks post conceptual age.
3. When home monitoring is prescribed for indications other than apnea/bradycardia in preterm infants, continuation of monitoring will be reviewed on a case-by-case basis.
4. Discontinuation of home monitoring should be a clinical decision based on a combination of clinical data and cardiorespiratory monitor event data.
5. Decisions regarding discontinuation of home monitoring should NOT be based on single-night pneumograms, which have no proven predictive value in this setting.