Policy: MP198
Section: Medical Benefit Policy
Subject: Pulse Oximetry for Pediatric Home Use

I. Policy: Pulse Oximetry for Pediatric Home Use

II. Purpose/Objective:
To provide a policy of coverage regarding Pulse Oximetry for Pediatric Home Use

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

Pediatric – For the purposes of this policy, the term pediatric will refer to Insured individuals under 21 years of age.

DESCRIPTION: Pulse Oximetry is a non-invasive method of monitoring arterial blood oxygenation. Changing absorbance of each of the two wavelengths is measured, allowing determination of the absorbances due to the pulsing arterial blood alone, factoring out venous blood, skin, bone, muscle, and fat. Based upon the ratio of changing absorbances of the red and infrared light caused by the difference in color between oxygen-bound and unbound hemoglobin in the blood, a measure of oxygenation can be made.

INDICATIONS:
Coverage for home pulse oximeters is subject to the terms, conditions and limitations outlined in the applicable benefit document.

A request for coverage requires a pre-certification through Medical Management or Designee. Equipment must be obtained through contracted Durable Medical Equipment vendors.

The use of home pulse oximetry may be considered medically necessary for the following indications when any of the qualifying criteria are met:

1. Pediatric patients who require mechanical ventilation; or
2. Infants with chronic lung disease (i.e. bronchopulmonary dysplasia); or
3. Infants on active therapy for Apnea (i.e. caffeine, tracheostomy); or
4. Pediatric patient diagnosed with chronic respiratory or cardiovascular disease requiring supplemental oxygen;

    AND

The insured individual meets all of the following criteria:

a. Oxygen needs vary from day to day or per activity (i.e. feeding, sleeping, movement); and
b. Medical need exists to maintain oxygen saturation within a very narrow range; and

EXCLUSIONS:
Current published peer-reviewed medical literature does not support the use of home pulse oximeters for pediatric patients outside of the current industry recognized guidelines. Therefore, the use of home pulse oximeters for indications other than those listed above is considered not medically necessary and is NOT COVERED.

CODING ASSOCIATED WITH: Pulse Oximetry for Pediatric Home Use

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

94760 Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)
94762 Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedures)
A4606 Oxygen probe for the use with oximeters device, replacement
E0445 Oximeter device for measuring blood oxygen levels non-invasively

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD’s and NCD’s will supersede this policy. For PA Medicaid Business segment, this policy applies as written.
REFERENCES:


Walsh, B and Smallwood, Pediatric oxygen therapy: a review and update. Respiratory Care, 2017;62 (6), 645-661

This policy will be revised as necessary and reviewed no less than annually.

Devised: 01/07

Revised: 2/08 (wording)