Medical Policy

Mobile Cardiac Outpatient Telemetry

Policy Number: OCA 3.356
Version Number: 6
Version Effective Date: 01/01/16

Product Applicability

☑ All Plan* Products

- Well Sense Health Plan
  ☐ New Hampshire Medicaid
  ☐ NH Health Protection Program

- Boston Medical Center HealthNet Plan
  ☑ MassHealth
  ☑ Qualified Health Plans/ConnectorCare/Employer Choice Direct
  ☑ Senior Care Options ◊

Notes:
* Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers the use of mobile cardiac outpatient telemetry (MCOT) to be experimental and investigational. It will be determined during the Plan’s prior authorization process if the service is considered experimental and investigational for the requested indication. See the Plan’s policy, Experimental and Investigational Treatment (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment.

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Description of Item or Service

Mobile Cardiac Outpatient Telemetry (MCOT): A mobile device that provides continuous, real-time ambulatory electrographic monitoring and analysis that is automatically activated. The device consists of a three (3)-electrode and a two (2)-channel sensor; the sensor transmits wirelessly to a small portable monitor which can be clipped to the waist or worn on a strap around the neck. Rhythm strips are recorded continuously and analyzed by an automated arrhythmia analysis algorithm. When an arrhythmia is detected, the monitor can transmit the ECG data to the monitoring center utilizing a cellular modem or telephone data line. The patient’s physician is made aware of arrhythmias based on pre-determined notification criteria, tailored to the patient by the physician.

MCOT, also known as real-time continuous attended cardiac monitoring system, is similar to ambulatory cardiac event monitoring but with these important differences: (1) Unlike the ambulatory cardiac event monitors (with non-continuous monitoring), the MCOT device is completely automatic, continuous, and requires no patient intervention to capture electrocardiographic data when an arrhythmia occurs; and (2) MCOT electrocardiographic data are automatically transmitted to a central service center for immediate interpretation when an arrhythmia is detected. Like ambulatory cardiac event monitoring, the duration of an MCOT study is typically up to 30 days. See Plan policy, Ambulatory Cardiac Event Monitors (Excludes Holter Monitors), policy number OCA 3.35, for additional information.

Medical Policy Statement

The Plan considers the use of mobile cardiac outpatient telemetry to be experimental and investigational.

Limitations

The use of mobile cardiac outpatient telemetry, including new and emerging technology used to monitor cardiac arrhythmia(s) (e.g., Zio Patch), is considered experimental and investigational.

Definitions

Arrhythmia: Irregular heart action secondary to a physiological or pathological disturbance in the discharge of electrical impulses or in the electrical transmission that cause dysfunction of the heart pumping mechanism. Examples of arrhythmia include bradycardia and tachycardia. Serious arrhythmias include ventricular tachycardia (VT) and ventricular fibrillation (VF). Both VT and VF are the primary causes of sudden death.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and Mobile Cardiac Outpatient Telemetry

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adapted in the United States by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

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<tr>
<th>CPT Codes</th>
<th>Description: Codes Considered Experimental and Investigational</th>
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<tr>
<td>93228</td>
<td>External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional</td>
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<tr>
<td>93229</td>
<td>External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional</td>
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**Clinical Background Information**

Cardiac arrhythmias occur when there is abnormal impulse formation or disordered conduction of electrical impulses within the myocardium. Depending on the type and severity, arrhythmias can cause palpitations, weakness, dizziness, syncope, hemodynamic complications, or death. Arrhythmias are classified as bradycardias when the heart rate falls below 60 bpm (beats per minute) and as tachycardia when the rate exceeds 200 bpm. The most dangerous type of tachycardia is ventricular
tachycardia; it can evolve into ventricular fibrillation, an arrhythmia that is fatal unless corrected immediately.

In contrast, supraventricular tachycardia originate in the atria and disrupt the normal electrical conduction pathways in the heart. Atrial fibrillation, a relatively common form of supraventricular tachycardia, occurs due to chaotic, uncoordinated electrical activity that causes the atria to quiver. Although atrial fibrillation is not usually life threatening, it can cause transient weakness and distress that, if prolonged, may lead to stroke or cardiac muscle damage.

A variety of treatments have been developed for arrhythmias including anti-arrhythmic drugs, artificial pacemakers, implanted cardiac defibrillators, and ablation of damaged or malfunctioning cardiac tissue. Selection of the appropriate treatment requires an accurate diagnosis, which may be difficult when arrhythmias occur infrequently, unpredictably, or are asymptomatic. To detect infrequent arrhythmias, patients can undergo 24 to 48 hours of continuous outpatient electrocardiographic (ECG) recording with a Holter monitor. Repeated monitoring sessions may be necessary if an arrhythmia does not occur during the first 1 or 2 days. Another method for detecting infrequent arrhythmias is the use of an event recorder, which stores 1 to 2 minutes of ECG data as soon as the patient experiences symptoms and presses a button to activate the device; although this technique enables a much longer period of monitoring, some arrhythmias are asymptomatic or some symptomatic patients may fail to activate the event recorder at the appropriate time.

Mobile cardiac outpatient telemetry (MCOT) provides continuous, outpatient ECG monitoring that is automatically activated and therefore requires no patient intervention. At the current time the overall quality of the peer reviewed published evidence is low for MCOT. Additional studies are needed to compare MCOT with auto-triggered loop monitors to determine whether diagnostic information obtained with MCOT improves health outcomes as a result of appropriate changes in treatments.

The Zio Patch is a new technology that competes with current care Holter monitoring, event monitoring, and mobile cardiac outpatient telemetry (MCOT). As the first commercially available, single-use ambulatory electrocardiographic (ECG) monitor, the Zio Patch provides continuous monitoring for up to 14 days for patients with suspected cardiac arrhythmia(s). The device is configured with a single lead, monitor, and data storage in an adhesive patch that is approximately 2 x 5 inches. Continuous ECG data are stored in an internal flash drive and a patch is applied to the patient’s left pectoral area, and the patient is instructed to wear the patch until it no longer adheres to their skin, or up to 14 days. Patients can press a button on the Zio Patch when they recognize a symptomatic episode. The patient mails the monitor to a central diagnostic testing facility for evaluation. Zio Patch is waterproof, small, and wire free, which may improve patient compliance with use of the device. Currently, there is insufficient scientific evidence in the peer reviewed medical literature to support the effectiveness of Zio Patch.

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References


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Strickberger SA, Benson DW, Biaggioni I, et al. AHA/ACCF Scientific Statement on the evaluation of syncope: from the American Heart Association Councils on Clinical Cardiology, Cardiovascular Nursing, Cardiovascular Disease in the Young, and Stroke, and the Quality of Care and Outcomes Research Interdisciplinary Working Group; and the American College of Cardiology Foundation: in collaboration with the Heart Rhythm Society: endorsed by the American Autonomic Society. Circulation 2006; 113:316.

Mobile Cardiac Outpatient Telemetry


<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date and Version Number</th>
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<tr>
<td>Regulatory Approval: N/A</td>
<td>02/01/12 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC and QIC</td>
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<td><strong>Review Date</strong></td>
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<td>12/01/12</td>
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Policy Revisions History

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<td>11/25/15</td>
<td>Review for effective date 01/01/16. Revised language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>11/25/15: MPCTAC (electronic vote)</td>
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Last Review Date

11/25/15

Next Review Date

10/01/16

Authorizing Entity

QIC

Other Applicable Policies

Medical Policy - *Ambulatory Cardiac Event Monitors (Excludes Holter Monitors)*, policy number OCA 3.35
Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Medically Necessary*, policy number OCA 3.14

Disclaimer Information: *

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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