TITLE: REAL-TIME MOBILE CARDIAC OUTPATIENT TELEMETRY (RT-MCOT)

EFFECTIVE DATE: June 17, 2019

This policy was developed with input from specialists in cardiology and endorsed by the Medical Policy Committee.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

These services may or may not be covered by all Medica plans. Please refer to the member’s plan document for specific coverage information. If there is a difference between this general information and the member’s plan document, the member’s plan document will be used to determine coverage. With respect to Medicare and Minnesota Health Care Programs, this policy will apply unless those programs require different coverage. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Medica utilization management policy may call the Medica Provider Service Center toll-free at 1-800-458-5512.

Medica utilization management policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of real-time mobile cardiac outpatient telemetry. The Benefit Considerations box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

I. Definitions

A. Real-time mobile cardiac outpatient telemetry (RT-MCOT), also known as continuous mobile cardiac outpatient telemetry (MCOT), allows clinicians to conduct real-time outpatient monitoring of patients’ cardiac rhythms via electrocardiographic recordings. The patient wears a portable electrocardiogram (ECG) sensor with leads attached to the skin for continuous monitoring of cardiac rhythms during daily activities. No patient intervention to either record or transmit an arrhythmia when it occurs is required. If the algorithm of the monitoring system detects an arrhythmic event, the system will automatically transmit the ECG data wirelessly or through a telephone line to a service center. Monitoring specialists analyze the data, respond to events, and report results in the manner prescribed by the physician. The patient can also manually send the ECG data by pressing a button when experiencing a symptom. The device may be worn for weeks at a time in order to evaluate infrequent or unpredictable symptoms suggestive of cardiac arrhythmias (e.g. palpitation, dizziness, or syncope) when non real-time cardiac monitoring is likely to have low diagnostic yield.

B. Cardiac ablation is a procedure used to correct abnormal heart rhythms (i.e., arrhythmias). Catheters are typically employed to scar or destroy heart tissue where the abnormal heart rhythm is being generated. This is intended to correct the arrhythmia by preventing further abnormal electrical signals from traveling through the heart. Cardiac ablation can be performed either through open-heart surgery or by minimally invasive techniques.

C. Cryptogenic stroke or transient ischemic attack (TIA) is a diagnosis made when the cause of an individual’s stroke or TIA cannot be found. The word cryptogenic means “of obscure or unknown origin”.

D. Occult atrial fibrillation refers to atrial fibrillation occurring without any readily discernible signs or symptoms. Occult is used in this context to mean “hidden.”

E. Syncope: A transient loss of consciousness and postural tone caused by diminished blood flow to the brain.
F. **Pre-syncope:** Presyncope refers to the sensation of lightheadedness and loss of strength that precedes a syncopal event or accompanies an incomplete syncope.

G. **Palpitation:** Forcible or irregular pulsation of the heart, perceptible to the patient, usually with an increase in frequency or force, with or without irregularity in rhythm. Palpitation can be a sign of underlying tachycardia.

H. **Tachyarrhythmia/tachycardia** is any irregularity of the heart rhythm in which the heart rate is abnormally increased (e.g., resting heart rate over 100 beats per minute).

**BENEFIT CONSIDERATIONS**

1. Prior authorization **is required** for real-time mobile cardiac outpatient telemetry (RT-MCOT) ordered outside the emergency room setting. Please see the prior authorization list for product specific prior authorization requirements.

2. Prior authorization is **not required** for RT-MCOT ordered in the emergency room setting. While prior authorization is not required, Medica reserves the right to conduct a medical necessity review following receipt of a claim submission for RT-MCOT.

3. Conditions other than those outlined in the medical necessity criteria are **investigative and therefore not covered**.

4. Coverage may vary according to the terms of the member’s plan document.

5. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member’s plan document.

6. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual’s case will be reviewed by the medical director or an external reviewer. Practitioners are reminded of the appeals process in their Medica Provider Administrative Manual.

**MEDICAL NECESSITY CRITERIA**

I. **Indications**

Real-time mobile cardiac outpatient telemetry (RT-MCOT) is considered medically necessary when documentation in the medical record indicates that **all of the following** criteria are met:

A. The RT-MCOT test is ordered by a cardiologist.

B. The individual has **one of the following** indications suggestive of a potentially significant cardiac event or condition:

   1. Unexplained syncope/pre-syncope or palpitation.

      NOTE: Potential origins of syncope/pre-syncope and palpitation included, but are not limited to, nonischemic dilated cardiomyopathy, hypertrophic cardiomyopathy, polypharmacy (e.g., ACE inhibitors and beta blockers), orthostatic intolerance, autonomic dysfunction, cerebrovascular disease.

   2. Medical monitoring/management required following cardiac ablation (e.g., antiarrhythmic or anticoagulant drug therapy).

   3. History of cryptogenic stroke or transient ischemic attack (TIA) indicating suspected unconfirmed occult atrial fibrillation.

**CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)**

For Medicare members, refer to the following, as applicable at: [http://www.cms.hhs.gov/mcd/search.asp](http://www.cms.hhs.gov/mcd/search.asp)

**DOCUMENT HISTORY**

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<th>Original Effective Date</th>
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<tbody>
<tr>
<td>MPC Endorsement Date(s)</td>
<td>02/2013, 04/2014, 02/2015, 04/2016, 04/2017, 04/2018, 04/2019</td>
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<td>05/01/2017</td>
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</tbody>
</table>

**References:**

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Pre-04/2016 Medical Policy Committee (MPC):


4. Calkins H, Brugada J, Packer DL, et al. HRS/EHRA/ECAS expert consensus statement on catheter and surgical ablation of atrial fibrillation: recommendations for personnel, policy, procedures and follow-up. A report of the Heart Rhythm Society (HRS) Task Force on Catheter and Surgical Ablation of Atrial Fibrillation developed in partnership with the European Heart Rhythm Association (EHRA) and the European Cardiac Arrhythmia Society (ECAS); in collaboration with the American College of Cardiology (ACC), American Heart Association (AHA), and the Society of Thoracic Surgeons (STS). Endorsed and approved by the governing bodies of the American College of Cardiology, the American Heart Association, the European Cardiac Arrhythmia Society, the European Heart Rhythm Association, the Society of Thoracic Surgeons, and the Heart Rhythm Society. Europace. 2007;9(6):335-379.


18. Podrid PJ. Ambulatory monitoring in the assessment of cardiac arrhythmias. In: UpToDate, Basow, DS (Ed), UpToDate, Waltham, MA, 2014.


04/2016 MPC:


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04/2018 MPC:


2019 MPC:
