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

EFFECTIVE DATE: April 23, 2018

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 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. 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. Continuous recorders: a type of ambulatory electrocardiography typically used for 24 to 48 hours to investigate symptoms and ECG events that are likely to occur within that time frame. The most common continuous recorder (also known as a Holter monitor) are battery operated portable devices that record the electrical activity of the heart via leads or electrodes attached to the chest and worn during activities of daily living. A physician analyzes the recording to identify heart rhythm abnormalities.

D. 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”.

E. An electrocardiogram (EKG, ECG) is a non-invasive recording of the electrical activity of the heart. An EKG is a non-ambulatory procedure and can be performed in a clinic or inpatient setting. Multiple electrodes are placed on the chest and connected in a specific order to the recording device, which measures electrical activity across all areas of the heart. A graph displaying the heart’s activity can be printed on paper or
transposed to a computer screen. The results are evaluated by trained personnel. EKG is considered the “gold standard” for measuring electrical heart activity.

F. A Holter monitor is an ambulatory device that continuously records heart rhythms. The monitor is usually worn for 24 - 48 hours during normal activity. Electrodes are affixed to the chest and attached to a small, battery-operated recording monitor worn in a pocket or small pouch at the neck or waist. The individual keeps a diary of daily activities, and after 24 - 48 hours, the monitor is brought to the physician’s office for evaluation and interpretation of results.

G. An intermittent recorder is a type of ambulatory electrocardiography typically used for long periods of time (weeks to months), which provides intermittent recordings for investigating events that occur infrequently. Some examples of intermittent recorders are loop recorders (implanted subcutaneously or worn externally) or patient/event recorders activated when the patient is experiencing symptoms. Cardiac monitors with expanded memory capabilities have been developed; however, these monitors may not be able to reliably discriminate between clinically significant arrhythmias and ECG artifacts.

H. Left atrial appendage (LAA) (also known as the left auricular appendix, auricula or left auricle) is a muscular pouch connected to the left atrium of the heart. There is no known function for the appendage. When the left atrial appendage does not beat consistently (i.e., atrial fibrillation) or dilates, the blood becomes stagnant and clots may form. These clots may then be released into the left atrium, travel to the brain, and cause a stroke.

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

J. Syncope: A transient loss of consciousness and postural tone caused by diminished blood flow to the brain.

K. Pre-syncope: Presyncope refers to the sensation of lightheadedness and loss of strength that precedes a syncopal event or accompanies an incomplete syncope.

L. 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.

M. Tachyarrhythmia is any irregularity of the heart rhythm in which the heart rate is abnormally increased.

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**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.

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**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
CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)
For Medicare members, refer to the following, as applicable at: http://www.cms.hhs.gov/mcd/search.asp?

DOCUMENT HISTORY

<table>
<thead>
<tr>
<th>Original MPC Effective Date</th>
<th>May 2012</th>
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<tbody>
<tr>
<td>Subsequent MPC Endorsement Date(s)</td>
<td>02/2013, 04/2014, 02/2015, 04/2016, 04/2017, 04/2018</td>
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<tr>
<td>Administrative Updates</td>
<td>05/01/2017</td>
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</tbody>
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References:

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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