

Clinical Policy: NICU Apnea Bradycardia Guidelines

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Date of Last Revision: 01/24

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The purpose of this guideline is to assist with continuity of care, discharge planning, and the transition to outpatient and home care of infants affected by ongoing neonatal apnea and bradycardia events. It also serves as a guideline for the approval of continued stay for neonatal admissions. The recommendations below are based primarily on meta-analyses and practice patterns, as there are few random controlled trials in this area.

Guidelines

Infants **may** be considered ready for discharge from inpatient care for cardiorespiratory events or caffeine administration when meeting the guidelines in I, as applicable.

- I. **Discharge from inpatient care for significant cardiorespiratory events**, all of the following:
 - A. Infant demonstrates maturity of respiratory control and one of the following:
 1. Infant has had no **clinically significant** cardiorespiratory events (apnea and bradycardia) for five to seven days prior to discharge and all of the following:
 - a. No apnea \geq 20 seconds;
 - b. No apnea $<$ 20 seconds with bradycardia of $<$ 80 beats per minute (may consider using a heart rate decrease $>$ 33.3% below baseline for older, more mature infants or those with a lower baseline heart rate);
 - c. No apnea $<$ 20 seconds with valid, prolonged or frequent oxygen desaturations \leq 85% (excludes transient oxygen desaturation \leq 85% unless requiring supplemental oxygen to resolve);
 - d. No bradycardia $<$ 70 beats per minute (unrelated to feedings);
 - e. No events requiring stimulation, artificial ventilation (bagging or intubation), or supplemental oxygen support to restore normal breathing, heart rate, and oxygenation;
 2. Significant events (as defined in I.A.1) continue to near-term or longer and all of the following:
 - a. After evaluation for potential causes of apnea, the cardiorespiratory events appear to be associated with gastro-esophageal reflux;
 - b. Appropriate anti-reflux measures appear to resolve or significantly reduce the severity and duration of bradycardia or apnea events (note: five days of observation may not be required in this case);
 3. The infant is having non-clinically significant, self-limited apnea spells (without color change or severe bradycardia) and all of the following:
 - a. Does not require stimulation to breathe again;
 - b. Will be discharged to home with a cardiorespiratory monitor;
 - c. There has not been a clinically significant cardiorespiratory event (defined in I.A.1) for five to seven days prior to discharge;

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- d. Parents or caregivers agree with the plan of care and have demonstrated proficiency in managing the cardiorespiratory monitor, providing stimulation, and have completed infant cardiopulmonary resuscitation (CPR) training;
 - e. Home situation has been assessed and deemed adequate;
- B. If nasal cannula airflow is introduced to address apnea/bradycardia events, the infant should be free of clinically significant events (defined in I.A.1) for five to seven days on the same level of support contemplated for the infant's discharge;
- C. Infant has not received caffeine citrate for at least seven days prior to planned discharge;
- D. No additional condition(s) requiring inpatient care.

Note:

- Cardiorespiratory events associated with feeding are not uncommon in premature infants due to incoordination of sucking, swallowing and breathing. The significance of these events should be evaluated on an individual basis (e.g., severity of bradycardia, degree of desaturation, intervention(s) required, etc.). Episodes associated with oral feedings may not be the same as episodes recorded while sleeping. Parents should be instructed in the technique of identifying feeding problems and correcting them.
- Caffeine has a relatively long half-life and levels may be therapeutic in preterm infants for as long as seven days or more after discontinuation. It is appropriate to observe an infant for seven days after the withdrawal of caffeine, but since the discontinuation often occurs well before discharge, a "caffeine countdown" should not typically prolong the date of discharge.^{1,2,3,5}
- An assessment of cardiorespiratory stability in a car seat is recommended prior to discharge for infants born at < 37 weeks gestation or with other risk factors for respiratory compromise (e.g., neuromuscular, orthopedic problems).
- Parents or caregivers are encouraged to attend an infant CPR class and required to complete CPR training as noted in I.A.3.d.
- Additional days may be needed for observation prior to discharge based on gestational age at birth and recorded events.

Background

Apnea of prematurity is a common condition of premature infants, often closely associated with bradycardia.^{4,6} The condition often results in prolonged lengths of stay in the neonatal intensive care units, as well as considerable parental anxiety. Each infant admitted to the neonatal intensive care unit (NICU) undergoes a unique hospital experience based upon their gestational age with discharge heavily dependent upon, at a minimum, the attainment of physiological maturity.⁷

The Committee on Fetus and Newborn has defined apnea of prematurity as a cessation of breathing that lasts for at least 20 seconds or is of shorter duration but accompanied by bradycardia, cyanosis or pallor in an infant younger than 37 weeks' gestational age. Most cases are resolved by 37 weeks' post-conceptual age; however, infants born at 24 to 28 weeks gestation frequently have apnea that persists longer, often to 44 weeks post-conceptual age.¹

Episodes of bradycardia may be associated with oral feedings and also with apnea events that occur while sleeping.⁶ Bradycardia associated with feeding that resolves with interruption of

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feeding is generally not regarded as a reason to delay discharge.^{4,8} Pathologic bradycardia (not associated with feeding) may be treated with pharmacologic or non-pharmacologic therapy. Non-pharmacologic measures include supplemental oxygen, artificial ventilation, and physical stimulation.⁶

Methylxanthine therapy, typically theophylline or caffeine, is the primary pharmacologic treatment for apnea of prematurity. Despite both agents having similar efficacy for decreasing episodes of apnea and bradycardia, results from a meta-analysis of five small trials of 108 infants noted considerably reduced adverse reactions with caffeine use versus theophylline use. Caffeine is recommended for infants with apnea of prematurity as an alternative to theophylline or supportive care alone.⁶ Caffeine citrate has a mean half-life of approximately 100 hours with some variation noted relative to gestational age at birth and chronological age.⁷ Because of its relatively long half-life in infants of < 33 weeks’ gestation, caffeine citrate has been ideal for once per day dosing in most infants. Also, because of the relatively large therapeutic index, the drug has been considered relatively safe. Maintenance dosing begins 24 hours after the loading dose at 5 to 10 mg/kg daily. Routine drug levels are not necessary unless there are signs of caffeine toxicity, such as tachycardia.^{6,9} Infants who fail to respond to caffeine therapy might require intubation, mechanical ventilation, or nasal intermittent positive pressure ventilation (NIPPV).⁶

Cardiorespiratory home monitoring is indicated when an infant has an ongoing medical condition that increases risk for apnea, airway obstruction, or hypoxemia. Such conditions include, but are not limited to, the following¹⁰:

- Persistent apnea of prematurity or apnea of infancy
- Chronic lung diseases (e.g., bronchopulmonary dysplasia), especially those requiring supplemental oxygen, positive airway pressure, or mechanical ventilatory support
- Congenital myasthenic syndromes
- Tracheostomy or other airway abnormalities.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created Specialist review – Neonatal Pulmonologist	06/13	06/13
Removed option in I.A. for preterm infants to be free of clinically significant events for 7 days vs. 5. Moved section III on home cardiorespiratory monitoring to background, except for requirement that caregiver attends CPR class, which was moved to criteria in I.3. Reviewed by pediatric pulmonologist, pediatrician, and neonatologist.	05/19	05/19
References reviewed and updated	05/20	05/20
References reviewed and updated.	04/21	05/21
In I.A.1 and I.B., changed requirement for no clinically significant events before discharge from “5” to “5-7” days. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.”	06/21	06/21

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Annual review completed. Expanded criteria I.A.3.c. into two criteria points by adding criteria I.A.3.d. Changed “child’s” to “infant’s” in criteria I.B. Reworded criteria former criteria I.E, now I.D., for clarity. Moved criteria I.E. and I.F. to notes section. Minor rewording in description, original notes, and background with no clinical significance. References reviewed and updated. Specialist reviewed.	06/22	06/22
Annual review. Minor rewording throughout criteria with no impact on criteria. Added clarifying language to Criteria I.A.1.c. and updated oxygen saturation percentage from < 85% to ≤ 85%. Updated wording in Criteria I.A.2.a. for clarity and flow. Updated Criteria I.A.2.b. to include verbiage for significantly reducing the severity and duration of bradycardia or apnea events. Updated Criteria I.A.3.d. to include that parents or caregivers agree with the plan of care. Added Criteria I.A.3.e. regarding the home situation being assessed and deemed adequate. Expanded information on CPR requirement in Note section at end of Criteria. Updated Note section at end of Criteria to include when additional observation days may be needed. Minor rewording in Background with no impact on criteria. References reviewed and updated. Criteria I.A.1.c., Criteria I.A.2.a., and Criteria I.A.2.b. reviewed by internal specialist. Policy reviewed by external specialist.	01/24	01/24

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Guidelines should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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