

# Clinical Policy: NICU Apnea Bradycardia Guidelines

Reference Number: LA.CP.MP.82

Last Review Date: 08/2020

[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 continuing care, discharge planning, and the transition to outpatient and home care of babies affected by ongoing neonatal apnea and bradycardia events. It will also serve as a guideline for the approval of continued stay for neonatal admissions. The recommendations below are based primarily off meta-analyses and practice patterns, as there are few 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 5 days prior to discharge, 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 oxygen desaturations  $<$  85% (excludes transient oxygen desaturation  $<$  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. Cardiorespiratory events appear, after evaluation for potential causes of apnea, to be associated with gastro-esophageal reflux;
      - b. Appropriate anti-reflux measures appear to resolve bradycardia or apnea (note: 5 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. Parents or caregivers have attended infant CPR training;
  - B. If nasal cannula airflow is introduced to address apnea/bradycardia events, the infant should be free of clinically significant events for 5 days on the same level of support contemplated for the child's discharge;
  - C. Infant has not received caffeine citrate for at least 7 days prior to planned discharge;

- D. Infant has no other condition(s) requiring inpatient care;
- E. 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);
- F. Parents or caregivers are encouraged to attend an infant CPR class.

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 needs to be assessed individually (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.

Note: Caffeine has a relatively long half-life and levels may be therapeutic in preterm infants for as long as 7 days or more after discontinuation. It is appropriate to observe an infant for 7 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.<sup>1-4, 6</sup>

### **Background**

Apnea of prematurity is a common condition of premature infants, often closely associated with bradycardia. The condition often results in prolonged lengths of stay in the neonatal intensive care units, as well as considerable parental anxiety. There is little objective evidence to recommend one.

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. The majority of preterm infants often cease to have apnea by 37 weeks’ post-conceptual age, however infants born at 24 to 28 weeks gestation have frequently been found to have apnea that persists longer, often to 44 weeks post-conceptual age.

Episodes of bradycardia may be associated with oral feedings and also with apnea events that occur while sleeping. Bradycardia associated with feeding that resolves with interruption of feeding is generally not regarded as a reason to delay discharge. 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.

When considering pharmacologic treatment, the most common agent used today is caffeine citrate. Loading doses of 20mg/kg have been used based on current references. Because of the relatively long half-life of caffeine citrate, as much as 87 hours in infants of < 33 weeks’ gestation, caffeine citrate has been ideal for once a day dosing in most babies. Also, because of the relatively large therapeutic index, the drug has been found to be relatively safe. Maintenance dosing begins 24 hours after the loading dose at 5-8 mg/kg daily. If there is no clinical improvement in the number of significant events, then a caffeine level may be obtained. The therapeutic trough serum concentration is 5 to 25 mg/L.<sup>6</sup>

Cardiorespiratory 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 following:

- Pharmacological treatment of respiratory immaturity or continued apnea at term or near-term gestation (apnea of prematurity or apnea of infancy)
- Chronic lung disease (eg, 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	Date	Approval Date
Converted corporate to local policy.	08/15/2020	

**References**

1. Alere. Neonatal clinical management guideline. Eighth edition. American Academy of Pediatrics Committee on Fetus and Newborn. Hospital discharge of the high-risk neonate. *Pediatrics* 2008; 122:1119.3.
2. Darnall RA, Kattwinkel J, Nattie C, Robinson M. Margin of safety for discharge after apnea in preterm infants. *Pediatrics*. 1997; 100:795–801.
3. Eichenwald EC, Abimbola A, Stark AR. Apnea Frequency Persists Beyond Term Gestation in Infants Delivered, at 24 to 28 Weeks. *Pediatrics* 1997; 100:3 354-359.
4. Eichenwald EC and Committee on Fetus and Newborn. Apnea of prematurity. *Pediatrics*, originally published online December 1, 2015; DOI: 10.1542/peds.2015-3757
5. Johns Hopkins HealthCare LLC. Optum Neonatal Clinical Management Guidelines Summary: Optum Neonatal Clinical Management Guidelines 9<sup>th</sup> Edition.
6. Loch SA, Srinivasan L, Escobar GJ. Epidemiology of Apnea and Bradycardia Resolution in Premature Infants. *Pediatrics*. 2011; 182(2):e366-e373.
7. Martin, Richard. Management of apnea of prematurity. In: UpToDate, Garcia-Prats JA, Mallory GB (Eds), July 30, 2019. Accessed May 1, 2020.
8. National Institutes of Health, Consensus Development Conference on Infantile Apnea and Home Monitoring, Sept 29 to Oct 1, 1986. *Pediatrics*.1987; 79:292.
9. Chandrasekharan P1, Rawat M1, Reynolds AM1, Phillips K2, Lakshminrusimha S1. Apnea, bradycardia and desaturation spells in premature infants: impact of a protocol for the duration of 'spell-free' observation on interprovider variability and readmission rates. *J Perinatol*. 2018 Jan;38(1):86-91.
10. Jeffries AL and Canadian Paediatric Society, Fetus and Newborn Committee. Going home: Facilitating discharge of the preterm infant. *Paediatr Child Health*. 2014 Jan; 19(1): 31–36.
11. Bodamer OA. Neuromuscular junction disorders in newborns and infants. UpToDate. Patterson MC, Martin R (Eds.) July 29, 2019. Accessed May 4, 2020.
12. Cowin MJ. Use of home cardiorespiratory monitors in infants. UpToDate. Mallory GB, Weisman LE (Eds.). August 28, 2019. Accessed May 4, 2020.

**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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

©2020 Louisiana Healthcare Connections. All rights reserved. All materials are exclusively owned by Louisiana Healthcare Connections and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied,

**CLINICAL POLICY**  
**NICU Apnea Bradycardia Discharge Guidelines**



modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Louisiana Healthcare Connections. You may not alter or remove any trademark, copyright or other notice contained herein. Louisiana Healthcare Connections is a registered trademark exclusively owned by Louisiana Healthcare Connections.