REIMBURSEMENT POLICY STATEMENT
OHIO MARKETPLACE PLANS

Original Issue Date	Next Annual Review	Effective Date
01/25/2018	07/01/2019	07/01/2018
Policy Name		**Policy Number**
Positive Airway Pressure Devices for Pulmonary Disorders		PY-0430
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Positive Airway Pressure Devices for Pulmonary Disorders

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Positive airway pressure (PAP) devices, involve using a machine that includes a mask or other device that fits over the nose and/or mouth to provide positive pressure to keep breathing airways open. Continuous positive airway pressure or CPAP is used to treat sleep-related breathing disorders including sleep apnea. It also may be used to treat preterm infants who have underdeveloped lungs. Bilevel or two level positive airway pressure or BiPAP is used to treat lung disorders such as chronic obstructive pulmonary disease (COPD). While CPAP delivers a single pressure, BiPAP delivers positive pressure both on inhalation and exhalation. PAP can provide better sleep quality, reduction or elimination of snoring, and less daytime sleepiness. The PAP machines should always be used according to the physician's order as well as every time during sleep at home, while traveling, and during naps in order to produce the most effective outcome

C. DEFINITIONS

- **Medically necessary** – health products, supplies or services that are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted guidelines of medical practice.
- **Compliance** – is the use of the device regularly as prescribed by the ordering physician and for 4 or more hours per night on 70% of nights.
- **Deviation** – is the altered or lack of use of the device as prescribed by the ordering physician.

D. POLICY

I. CareSource does not require a prior authorization for the first 3 month rental on a PAP machines (CPAP/BiPAP) for participating providers.
   A. CPAP (E0601) machines and BiPAP (E0470) are a 13 month rent to purchase.
   B. Prior authorization must be obtain through CareSource starting after the 3rd month rental (months 4-13).
   C. CareSource follows the Local Coverage Determination (LCD) L33718 for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea for medical necessity determination.

II. Providers that dispense the PAP machine must ensure and document the member's compliance with its use.
   A. CareSource considers compliance with the use of PAP as the following:
      1. The member uses the device regularly as prescribed by the ordering physician.

2. If there is a discontinuation of use at any time, the PAP supplier is expected to ascertain adherence and stop billing for the equipment, related accessories and supplies.
3. In accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines, compliance is defined as use of PAP for 4 or more hours per night on 70% of nights during a consecutive 30-day period anytime during the first 3 months of initial use of the PAP device and throughout the entire 13 month rental period.

III. Member's that are not compliant with the use of their PAP machines will not be authorized further rental.
   A. Any reimbursement, for the PAP machine, that was dispensed during the time of deviation will be recouped by CareSource.
   B. Any supplies that were dispensed during the time of deviation will be recouped by CareSource.

Note: Although CareSource does not require a prior authorization during the first 3 months of use, CareSource may request documentation to support medical necessity that shows the member's compliance with the use of the PAP machine. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

E. CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting Centers for Medicare & Medicaid Services (CMS) approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the CMS fee schedule https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

- **The following list of codes is provided as a reference. This list may not be all inclusive and is subject to updates. Please refer to the above referenced source for the most current coding information.**

Code	Description
A4604	Tubing with integrated heating element for use with positive airway pressure device
A7030	Full face mask used with positive airway pressure device
A7031	Face mask interface, replacement for full face mask
A7032	Cushion for use on nasal mask interface, replacement only
A7033	Pillow for use on nasal cannula type interface, replacement only, pair
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035	Headgear used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, non-disposable, used with positive airway pressure device
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface
E0601	Continuous positive airway pressure (CPAP) device

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/25/2018	New Policy.
Date Revised		
Date Effective	07/01/2018	

H. REFERENCES

1. CPAP - NHLBI, NIH. (2018, January 5). Retrieved 1/5/2018 from https://www.nhlbi.nih.gov/health/health-topics/topics/cpap
2. Local Coverage Determination (LCD) for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718) (2017, January 1). Retrieved 1/5/2018 from https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33718&ver=12&DocID=L33718&bc=KAAAABAAAAAAAA%3d%3d&
3. Positive Airway Pressure (PAP) Devices: Complying with Documentation & Coverage Requirements. (2016, October). Retrieved 1/5/2018 from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PAP_DocCvg_FactSheet_ICN905064.pdf

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.