MEDICAL POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Date Effective
Positive Airway Pressure Devices for Pulmonary Disorders		MM-1019	10/01/2020
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement 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.

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A. Subject

Positive Airway Pressure Devices for Pulmonary Disorders

B. Background

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

- **Adherence –** is defined by CareSource as the use of the device regularly used as prescribed by the ordering physician, the use of PAP device for 4 or more hours per night for 70% of the nights during the most recent consecutive 30-day period during the first initial usage.

D. Policy

I. CareSource does not require prior authorization for participating providers for the first 3 month rental on a PAP machine (CPAP/BiPAP)
   A. CPAP and BiPAP machines are a 10 month rent to purchase.
   B. Prior Authorization must be obtained through CareSource starting after the 3rd month rental (months 4-10).
   C. Documentation that confirms adherence must be submitted with the prior authorization request.
   D. Providers that dispense the PAP machine must ensure and document the members adherence with the following
      1. The use of 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.

II. CareSource will use MCG Health guidelines for medical necessity.

NOTE: Although CareSource does not require a prior authorization during the initial 3 months of use, CareSource may request documentation to support medical necessity that shows adherence to the ordered use of the PAP machine. Appropriate and complete documentation must be presented at the time of review to validate medical necessity.

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E. Conditions of Coverage

F. Related Policies/Rules

Positive Airway Pressure Devices for Pulmonary Disorders PY-0313

G. Review/Revision History

	DATE	ACTION
Date Issued	06/10/2020	
Date Revised		
Date Effective	10/01/2020	New Medical Policy
Date Archived	08/01/2021	

H. References

1. Lawriter-OAC-5160-1-01 Medicaid Medical necessity: definitions and principles (2015, March 22) Retrieved 05/19/2020.
2. Local Coverage Determination (LCD) for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33781) (2019, January 1) Retrieved 05/19/2020 from www.cms.gov
3. CPAP-NHLBI, NIH (2019, July) Retrieved 05/19/2020 from www.nhlbi.nih.gov

This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

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

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