CareSource

MEDICAL POLICY STATEMENT
OHIO MEDICAID

Policy Name	Policy Number	Date Effective
Positive Airway Pressure Devices for Pulmonary Disorders	MM-1019	08/01/2021-08/31/2022

Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CareSource and its affiliates 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 CareSource and its affiliates 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

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. Bi-level 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 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.
- **Bi-level Positive Airway Pressure (BiPAP) device** – is a device that uses mild bi-level or two levels of air pressure to keep your breathing airways open.
- **Continuous Positive Airway Pressure (CPAP) device** – is a device that uses mild continuous air pressure to keep your breathing airways open.
- **Positive Airway Pressure (PAP) device** – is a device that uses air pressure to keep your breathing airways open. PAP includes both continuous positive airway pressure (CPAP) devices and bi-level positive airway pressure (BiPAP) devices.

D. Policy

I. PAP devices addressed in this policy are:
   A. E0601 – CPAP, continuous pressure capability, used with noninvasive nasal or face mask. This item is a rent to purchase.
   B. E0470 – BiPAP, Bi-level pressure capability, without backup rate feature, used with noninvasive nasal or face mask. This item is a rent to purchase
   C. E0471 – BiPAP, Bi-level pressure capability, with backup rate feature, used with noninvasive nasal or face mask. This item is a rental only.
   D. E0472 – BiPAP, Bi-level pressure capability, with backup rate feature, used with invasive tracheostomy tube. This item is a rental only.

II. CareSource uses MCG Health clinical criteria to determine medical necessity
   A. PAP devices CPAP (E0601) and BiPAP (E0470):

1. During the first 3 months rental for a CPAP (E0601) or BiPAP (E0470) positive airway pressure (PAP) device, CareSource considers the device
2. medically necessary when the MCG Health clinical criteria are met.
   For months 4-10 rental for a CPAP (E0601) or BiPAP (E0470) positive airway pressure (PAP) device, CareSource considers the device medically necessary when:
   a. The MCG Health clinical criteria are met **AND**;
   b. Documentation that confirms adherence, as defined above, must be submitted.

   Note: CPAP (E0601) and BiPAP (E0470) machines are a 10 month rent to purchase.

III. CareSource uses MCG Health clinical criteria to determine medical necessity
   A. PAP devices BiPAP (E0471) and BiPAP (E0472)
      1. During the rental period for a BiPAP (E0471) and BiPAP (E0472) positive airway pressure (PAP) device, CareSource considers the device medically necessary when the MCG Health clinical criteria are met.

      Note: BiPAP machines E0471 and E0472 are a continuous rental and never cap out as a purchase.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	06/10/2020	New policy
Date Revised	03/31/2021	Revised medical necessity criteria language. Added definitions. Clarified types of PAP devices.
Date Effective	08/01/2021	
Date Archived	08/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

1. American Academy of Sleep Medicine (2021) Practice Guidelines. Retrieved 03/10/2021 from www.aasm.org.

2. CMS. Local Coverage Determination for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718). (2020, February 26). Retrieved 03/10/2021 from www.cms.gov.
3. Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) (2021). Retrieved 03/10/2021 from www.medicaid.ohio.gov.
4. MCG Health guidelines. 24th ed. A-0994 Bi-level Positive Airway Pressure (BPAP) Device (2020). Retrieved 03/10/2021 from www.careweb.careguidelines.com.
5. MCG Healthcare guidelines. 24th ed. A-0431 Continuous Positive Airway Pressure (CPAP) Device (2020). Retrieved 03/10/2021 from www.careweb.careguidelines.com.
6. U.S. Department of Health & Human Services. National Heart, Lung and Blood Institute. (2021) CPAP. Retrieved 03/10/2021 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.