Positive Airway Pressure Devices for the Treatment of Obstructive Sleep Apnea

I. Policy

University Health Alliance (UHA) will reimburse for positive airway pressure devices for the treatment of obstructive sleep apnea (OSA) when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Definitions

A. Apnea is defined as the cessation of airflow for at least 10 seconds.

B. Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds associated with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation.

C. The Apnea-Hypopnea Index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device.

D. The Respiratory Disturbance Index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device.

E. If the AHI or RDI is calculated based on less than 2 hours of sleep or recorded time, the total number of recorded events used to calculate the AHI or RDI (respectively) must be at least the number of events that would have been required in a 2 hours period (i.e., must reach greater than or equal to 30 events without symptoms or greater than or equal to 10 events with symptoms.

III. Criteria/Guidelines

A. Continuous positive airway pressure (CPAP) device is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of obstructive sleep apnea (OSA) when the following criteria are met:

1. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess for sleep related breathing disorder. The evaluation should include the following:
   a. Signs and symptoms of sleep disordered breathing, e.g., habitual snoring, observed apneas, choking or gasping, excessive daytime sleepiness, morning headaches;
   b. Duration of symptoms;
   c. Comorbid conditions, e.g., hypertension, ischemic heart disease, stroke;

2. Clinically significant OSA is documented by a polysomnogram performed by an appropriately accredited facility that demonstrates either of the following:
   a. The Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour; or,
   b. The AHI or RDI is greater than or equal to five and less than 15 events per hour with a minimum of 10 events and documentation of any of the following:
      A. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
B. Hypertension, ischemic heart disease, or history of stroke.

3. PAP titration has been initiated (and in most cases completed).

4. The patient and/or their caregiver have received or will receive instruction from the supplier of the CPAP device and accessories in the proper use and care of the equipment.

B. Respiratory assist device (RAD) without back-up rate is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of OSA when both the following criteria are met:

1. Criteria for CPAP device (III.A.1 through 3) are met.

2. CPAP device has been tried and proven ineffective or not tolerated based on a therapeutic trial conducted in either a facility or home setting.

C. The use of CPAP or RAD beyond the first three months of therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when:

1. Direct download or visual inspection of data from the device has been performed and adherence has been documented. Adherence to therapy is defined as use of PAP device greater than or equal to four hours per night on 70% of nights during a consecutive thirty day period during the third month of usage.

D. Oral appliances, including tongue-retaining or mandibular advancing/positioning devices, are covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of OSA when the following criteria are met:

1. Criteria for CPAP are met; and

2. Patient has mild to moderate OSA (i.e., AHI greater than or equal to five and less than 30) and PAP device has been offered and patient declines treatment; or

3. Patient has severe OSA (i.e., AHI greater than or equal to 30) and RAD has been tried and could not be tolerated;

4. The device is prescribed by the treating physician following review of the sleep test;

5. The device is provided by a licensed dentist (DDS or DMD).

E. Accessories used with a PAP device are covered when coverage criteria of the PAP device are met.

F. Either a non-heated or heated humidifier is covered when ordered by the treating physician for use with a covered PAP device.

G. **NOTE:**

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.
IV. Limitations/Exclusions

A. Polysomnogram should be performed in accordance with UHA Polysomnography-Sleep Studies policy criteria.

B. A PAP device is only covered as a capped rental item.

C. This policy only applies to the use of RAD for the treatment of OSA. For other diagnoses (including central and complex sleep apnea) this policy does not apply.

D. A RAD with back-up rate (E0471) is generally not covered if the primary diagnosis is OSA. For other diagnoses, refer to Medicare LCD for Respiratory Assist Devices.

E. If a PAP device reaches its five year life expectancy, but is in good working order and meets the patient's medical needs, a replacement device will not be covered.

F. A repeat sleep study is not necessary for replacement of a PAP device.

G. The use of home oxygen therapy as the sole treatment of OSA, i.e. in the absence of positive airway pressure, is not covered as it is not the most appropriate level of service.

H. If there is discontinuation of usage of a PAP device at any time, the supplier is expected to ascertain this and stop billing for the equipment and related accessories and supplies.

V. Administrative Guidelines

A. Prior authorization is required for initial and continued use of RAD (BiPAP).
   1. For initial use, the following documentation from the medical record must be submitted:
      a. Face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for sleep related breathing disorder;
      b. Polysomnogram results supporting diagnosis of OSA and response to PAP device. Therapeutic portion of the study showing results of titration of positive pressure device must be submitted;
      c. Documentation supporting that CPAP device has been tried and proven ineffective or not tolerated based on a therapeutic trial conducted in either a facility or home setting. If in a home setting, a face-to-face clinical evaluation by the treating physician documenting ineffectiveness of or intolerance to CPAP device must be submitted.
   2. For continued use, the following documentation from the medical record must be submitted:
      a. Face-to-face clinical reevaluation by the treating physician supporting improvement in symptoms; and
      b. Documentation supporting adherence to therapy.

B. Prior authorization is required for oral appliances. The following documentation from the medical record must be submitted:
   1. Polysomnogram results supporting diagnosis of OSA.
   2. For mild to moderate OSA, documentation supporting that PAP device has been offered and declined by patient.
   3. For severe OSA, documentation supporting that RAD device has been tried and not tolerated.
C. Prior authorization is not required for initial and continued use of CPAP for the treatment of OSA when criteria are met. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and made available to UHA upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

D. For CPAP with C-flex and auto-titrating CPAP, code E0601 should be used.

E. To request prior authorization, please go to UHA's website: http://www.uhahealth.com/forms/form_request_auth.pdf and submit it:

   Via Fax: 1-866-572-4384

   Via Mail:
   UHA Health Care Services
   700 Bishop Street, Suite 300
   Honolulu, HI 96813

<table>
<thead>
<tr>
<th>HCPCS codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>E0470</td>
<td>Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)</td>
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<tr>
<td>E0471</td>
<td>Respiratory assist device, bi-level pressure capability, backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)</td>
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<tr>
<td>E0601</td>
<td>Continuous airway pressure (CPAP) device</td>
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<tr>
<td>E0485</td>
<td>Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment</td>
</tr>
<tr>
<td>E0486</td>
<td>Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment</td>
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VI. Policy History

Policy Number: M.DME.07.120301
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Previous Revision Dates: N/A