



Sleep Apnea: Treatment

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) and Auto-adjusting positive airway pressure (APAP) devices are 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; and
 - 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 or home study which demonstrates that the Apnea-Hypopnea Index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 5 events per hour.
 - 3. CPAP will not be covered unless PAP titration has been initiated (and in most cases completed).
 - a. If PAP cannot be titrated during supervised polysomnography performed in a sleep laboratory, then either a repeat PSG or auto-adjusting CPAP will be covered, subject to the criteria in the UHA Sleep Apnea: Diagnosis policy.
 - b. Auto-adjusting positive airway pressure (APAP) is also covered for PAP titration in the home setting when the diagnostic study demonstrates OSA and there are no

contraindications to home titration, subject to the criteria in the UHA Sleep Apnea: Diagnosis policy.

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) is covered (subject to Limitations/Exclusions and Administrative Guidelines) for the treatment of OSA when all of the following criteria are met:
1. Criteria in this policy for CPAP device are met; and
 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. Ineffective is defined as documented failure to meet therapeutic goals using a CPAP device during the titration portion of a facility-based study or during home use despite optimal therapy, i.e., proper mask selection and fitting and appropriate pressure settings.
- C. Custom fitted or custom fabricated 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 or equal to 30) and PAP device has been offered and patient declines treatment or PAP devices have been tried and could not be tolerated; or
 3. Patient has severe OSA (i.e., AHI greater than or equal to 30) and PAP and RAD (bi-level PAP device) 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).
- D. Accessories used with a PAP device are covered when coverage criteria of the PAP device are met.
- E. Either a non-heated or heated humidifier is covered when ordered by the treating physician for use with a covered PAP device.

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. A PAP device is covered only as a capped rental item.
 1. A capped rental is defined as covered up to the purchase price of the PAP device
- B. This policy only applies to the treatment of OSA. For other diagnoses (including central and complex sleep apnea) this policy does not apply.

- C. A RAD with back-up rate (E0471) is for a primary diagnosis of OSA, unless the prescribed inspiratory pressure exceeds the capability of RADs without back-up (generally an inspiratory pressure greater than 25 cm H₂O).
- D. 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.
- E. Replacement of PAP device is covered when the member's current device is obsolete and cannot be repaired or is out of warranty. All of the following documentation is required:
 - 1. The diagnostic sleep study showing criteria for PAP is met; and
 - a. A repeat sleep study is not necessary for replacement of a PAP device.
 - 2. Physician's clinical notes; and
 - 3. Physician order for replacement PAP device; and
 - 4. A letter from the manufacturer indicating the member's current device is obsolete and cannot be repaired or is out of warranty.
- F. 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.
- G. 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.
- H. An oral interface used with respiratory suction pump (HCPCS code A7047) is not covered as it is not known to be effective in improving health outcomes.

V. Administrative Guidelines

- A. Prior authorization is required for use of CPAP, APAP and RAD (Bilevel PAP) for the treatment of OSA when all criteria are met:
 - 1. 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 a sleep related breathing disorder;
 - b. Polysomnogram results supporting diagnosis of OSA and results from the therapeutic portion of the study showing the PAP titration results.
 - 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 the trial was conducted 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.
- 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. Product name, manufacturer/distributor and model of device; and
 - 3. For mild to moderate OSA, documentation supporting that PAP device has been offered and declined by patient or a PAP device has been tried and not tolerated;
 - a. For mild OSA, E0486 is covered at \$550;
 - 4. For severe OSA, documentation supporting that RAD device has been tried and not tolerated.
- C. To request prior authorization, please submit via UHA's online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

HCPCS Code	Description
E0470	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)
E0471	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)
E0485	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment
E0486	Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment
E0601	Continuous airway pressure (CPAP) device

VI. Policy History

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