MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Positive Airway Pressure Devices for Pulmonary Disorders Continued Rental-OH MCD-MM-1019	07/01/2024
Policy Type	
MEDICAL	

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 Continued Rental

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, (CPAP) treats 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 (BiPAP) treats 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. 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** – The use of the device regularly as prescribed by the ordering physician 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** – A device that uses mild bi- level or 2 levels of air pressure to keep breathing airways open.
- **Continuous Positive Airway Pressure (CPAP) Device** – A device that uses mild continuous air pressure to keep breathing airways open.
- **Positive Airway Pressure (PAP) Device** – A device using air pressure to keep breathing airways open, including 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 as follows:
   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. PAP devices CPAP (E0601) and BiPAP (E0470):
   A. A. Initial prior authorization review: 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 medically necessary when Ohio Administrative Code clinical criteria are met.

B. For continued rent to purchase period
   1. For months 4-10 rental for a CPAP (E0601) or BiPAP (E0470) positive airway pressure (PAP) device.
      a. 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. PAP devices BiPAP (E0471) and BiPAP (E0472) CareSource uses MCG Health and/or OAC clinical criteria to determine medical necessity
   A. 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 05/11/2022 03/15/2023 02/28/2024	Revised medical necessity criteria language. Added definitions. Clarified types of PAP devices. No changes. Updated references. Approved at PGC. Added Ohio Administrative Code language. Updated references. Approved at Committee. Annual review. Removed MCG from initial review and supply chain statement. Updated references. Approved at Committee.
Date Effective	07/01/2024	
Date Archived		

H. References
1. *Practice Guidelines*. American Academy of Sleep Medicine; 2024. Accessed February 14, 2024. www.aasm.org

2. *Local Coverage Determination: Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea*. Medicare Coverage Database; 2024. LCD ID L33718. Accessed February 14, 2024. www.cms.gov
3. Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers, OHIO ADMIN. CODE 5160-10-1 to 80. Accessed February 15, 2024. www.codes.ohio.gov
4. Bi-level Positive Airway Pressure (BPAP) Device: A-0994. MCG. 27th ed. Accessed February 15, 2024. www.careweb.careguidelines.com
5. Continuous Positive Airway Pressure (CPAP) Device: A-0431. MCG. 27th ed. Accessed February 15, 2024. www.careweb.careguidelines.com
6. DMEPOS: Positive Airway Pressure Devices, OHIO ADMIN. CODE 5160-10-19 (2021).
7. CPAP. National Heart, Lung and Blood Institute, U.S. Dept of Health & Human Services. 2022. Accessed February 15, 2024. 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.

ODM Approved 03/28/2024