


<p align="center">MEDICAL POLICY</p>	<p align="center">Temporary Policy Emergency Provisions for:</p> <p align="center">Sleep Disorder Treatment: Positive Airway Pressure (Medicare Only)</p>
<p>Effective Date: 05/01/2021 for Annual Review</p> <p>60 day effective period for temporary policy provisions beginning 4/1/2021</p>  <p align="right">5/1/2021</p>	<p align="center">Medical Policy Number: 53</p> <hr/> <p>Medical Policy Committee Approved Date: 1/18; 1/19; 12/19; 7/2020; 9/2020; 11/2020; 1/2021; 04/2021</p>
<p>Medical Officer Date</p>	

See Policy HCPCS CODE section below for any prior authorization requirements

NEED AND DURATION OF EMERGENCY PROVISIONS

1. **Need for the temporary Provisions: COVID-19 public health emergency**
2. **Documents or source relied upon:** Centers for Medicare & Medicaid Services (CMS) released [“Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19”](#)
3. **Initial Effective Date: 3/1/2020**
4. **Re-review dates: 5/27/2020; 7/22/2020; 9/23/2020; 11/30/2020; 2/3/2021**
5. **Termination Date: 6/1/2021**
6. **Next Reassessment Date determined at Companies sole discretion: 05/26/2021**

POLICY ADDENDUM

COVID-19 Public Health Emergency

On March 30th, 2020, the Centers for Medicare & Medicaid Services (CMS) released [“Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19”](#), which states:

National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) on Respiratory Related Devices, Oxygen and Oxygen Equipment, Home Infusion Pumps and Home Anticoagulation Therapy: Clinicians now have maximum flexibility in determining patient needs for respiratory related devices and equipment and the flexibility for more patients to manage their treatments at the home. The current NCDs and LCDs that restrict coverage of these devices and services to patients with certain clinical characteristics do not apply during the public health emergency. For example, Medicare will cover non-invasive ventilators, respiratory assist devices and continuous positive airway pressure devices based on the clinician’s assessment of the patient.

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Therefore, beginning 3/30/2020, the Medicare Guidelines below do not apply during this public health emergency. During this time, the DME addressed in this medical policy will be covered based on the clinician’s assessment of the patient.

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
<i>Positive Airway Pressure Therapy for Obstructive Sleep Apnea (OSA)</i>	<ul style="list-style-type: none"> National Coverage Determination (NCD): Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (240.4)¹ <i>Note: The NCD provides more detailed criteria on the sleep testing requirements for the OSA diagnosis (see criterion B.3. and B.4.)</i> Local Coverage Determination (LCD): Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)² Local Coverage Article (LCA): Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (A52467)³
<i>Positive Airway Pressure for non-OSA Breathing Disorders (e.g., Central Sleep Apnea)</i>	<ul style="list-style-type: none"> LCD: Respiratory Assist Devices (L33800)⁴ LCA: Respiratory Assist Devices - Policy Article (A52517)⁵

Per the [Medicare Policy Manual](#) commercial medical policies may be applied to Medicare coverage determinations in the absence of an appropriate NCD, LCD, LCA, or CMS Coverage Manual. Therefore, the commercial medical policy, **Sleep Disorder Treatment: Positive Airway Pressure (All Lines of Business Except Medicare)** applies to the following services:

- Requests for Positive Airway Pressure not addressed by guidance in the criteria above

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HCPCS CODES

Medicare Only	
Prior Authorization Required	
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, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0601	Continuous positive airway pressure (cpap) device

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHA Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

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MEDICAL POLICY CROSS REFERENCES

- Sleep Disorder Testing (All Lines of Business Except Medicare)
- Sleep Disorder Testing (Medicare Only)
- Sleep Disorder Treatment: Positive Airway Pressure (All Lines of Business Except Medicare)
- Sleep Disorder Treatment: Positive Airway Pressure (Medicare Only)
- Sleep Disorder Treatment: Surgical (All Lines of Business Except Medicare)
- Sleep Disorder Treatment: Surgical (Medicare Only)

REFERENCES

1. Centers for Medicare & Medicaid Services: National Coverage Determination (NCD) for Continuous Positive Airway Pressure (CPAP) Therapy For Obstructive Sleep Apnea (OSA) (240.4). Effective Date of this Version: 3/13/2008. Implementation Date: 8/4/2008. <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=226>. Accessed 02/25/2021.
2. Centers for Medicare & Medicaid Services: Local Coverage Determination (LCD): Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718). Revision Effective Date: For services performed on or after 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33718>. Accessed 02/25/2021.
3. Centers for Medicare & Medicaid Services Local Coverage Article: Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article (A52467). Revision Effective Date: 04/03/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52467>. Accessed 02/25/2021.
4. Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Respiratory Assist Devices (L33800). Revision Effective Date: For services performed on or after 01/01/2020. <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33800>. Accessed 02/25/2021.
5. Centers for Medicare & Medicaid Services Local Coverage Article: Respiratory Assist Devices - Policy Article (A52517). Revision Effective Date: 04/03/2020. <https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52517>. Accessed 02/25/2021.