Group Plan Solutions
Benefit Administration
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Obstructive Sleep Apnea Treatment

The following payment policies apply to medically necessary non-surgical treatments for Obstructive Sleep Apnea rendered by in-network or out-of-network providers. Benefits are not guaranteed prior to a claim being submitted and approved. The eligibility of benefits is based on the specific Plan's provisions, exclusions, and limitations. Review the Plan's precertification requirements to determine if precertification is necessary. If there is a difference between this information and your plan documents, your plan documents will be used to determine your coverage.

Description

This document addresses positive airway pressure devices as a treatment for obstructive sleep apnea (OSA). OSA is determined through a polysomnography, or a home/portable sleep study.

MEDICAL CRITERIA

Coverage for continuous positive airway pressure (CPAP), auto-titrating positive airway pressure (APAP), and bi-level positive airway pressure (BPAP) devices is subject to the terms, conditions and limitations of the applicable benefit plan's Durable Medical Equipment (DME) benefit and schedule of copayments. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions, and limitations of coverage.

Monthly rental for a CPAP, or auto-titrating PAP (APAP) will be covered for an initial 60 day period as medically necessary for the treatment of OSA in an adult (18 years or older) when EITHER of the following criteria is met:

- Apnea/hypopnea index (AHI) greater than, or equal to 15 as documented by polysomnography (PSG) or home/portable sleep study when used as part of a comprehensive sleep evaluation.
- AHI greater than or equal to 5 and less than 15 as documented by PSG or home/portable sleep study, when accompanied by symptoms of OSA (e.g., excessive daytime sleepiness, impaired cognition, mood disorders or insomnia), or when the individual has hypertension, ischemic heart disease or history of stroke

Monthly rental for a CPAP or auto-titrating PAP (APAP) for an initial 60 day period as medically necessary for the treatment of OSA in a child when ALL of the following criteria are met:

- OSA diagnosis established by PSG
- Child weighs 66 pounds or more
- Adenotonsillectomy has been unsuccessful, or is contraindicated, or when definitive surgery is indicated but must await complete dental and facial development

Monthly rental for a bi-level positive airway pressure (BPAP) for an initial 60 day period as medically necessary for the treatment of OSA for an individual with coexisting central hypoventilation, or for an individual who requires, but proves intolerant to high pressures of CPAP or APAP.

The Plan will continue the CPAP, APAP, or BPAP therapy beyond the initial 60 day rental period when adequate adherence to therapy is demonstrated. The following criterial must be met:

- Demonstrated compliant use of the device with download data provided by the provider at 2 and 6 months
    - Compliance is defined as use of positive airway pressure four (4) or more hours per night on at least 70% of nights during a consecutive thirty (30) day period anytime during the initial period of usage.
- If documented use is less than stated above, description of malfunction and documentation that equipment has been sent for repair/assessment must be provided.

The CPAP, APAP, or BPAP machine will be considered paid in full after a 10 month rental period.

The following accessories and supplies are considered medically necessary for members who meet criteria for positive airway pressure devices (duplication of services is not allowed; i.e. 2 different masks at same time):

- Chinstrap
- Full face mask with positive airway pressure device
- Headgear
- Water Chamber every 2 years
- Nasal interface (mask or cannula type) for positive airway pressure device
- Oral interface for positive airway pressure device
- Replacement cushions and pillows for nasal application device
- Replacement interface for full face mask
- Tubing for heated or non-heated humidifier
- Non-disposable filter
- Disposable filter

Initial purchase and replacement of any of the above supplies for use with CPAP, APAP, or BPAP as medically necessary are allowed at a frequency of no more often than every 3 months.

Coverage for oral appliances may be subject to the terms, conditions and limitations of the applicable benefit plan. Please refer to the applicable benefit plan document to determine benefit availability and terms, conditions and limitations of coverage. If coverage for oral appliances is available, the following conditions of coverage apply.

Coverage for a tongue-retaining device or a mandibular repositioning appliance (HCPCS codes E0485, E0486, S8262)), also referred to as mandibular advancement appliance or mandibular advancement splint, is allowed as medically necessary for an individual with mild or moderate OSA when EITHER of the following criteria is met:

- Apnea/hypopnea index (AHI) greater than or equal to 15 and less than 30, as documented by polysomnography (PSG) or home/portable sleep study
- AHI greater than or equal to 5 and less than15 as documented by PSG or home/portable sleep study, when accompanied by symptoms of OSA (e.g., excessive daytime sleepiness, impaired cognition, mood disorders or insomnia) or when the individual has hypertension, ischemic heart disease or history of stroke

Not Medically Necessary

Over-the-counter (OTC) oral appliances that can be obtained without a prescription are excluded under many benefit plans and therefore are generally not covered. In addition, OTC oral appliances are not considered medically necessary.