HIGHMARK Delaware
HEALTH OPTIONS

CLINICAL MEDICAL POLICY	
Policy Name:	Noninvasive Positive Pressure Intermittent Ventilation in the Home Setting
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Responsible Department(s):	Medical Management
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Products:	Highmark Health Options Medicaid
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Page Number(s):	1 of 14

DISCLAIMER

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage as a Durable Medical Equipment (DME) benefit of the Company's Medicaid products under its medical benefits for medically necessary intermittent noninvasive positive pressure ventilation (NPPV) devices in the home setting.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Apnea – The cessation of airflow for at least ten seconds.

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

Bi-level Positive Airway Pressure (BiPAP) – Bi-level positive airway pressure is a type of noninvasive ventilation that helps keep the upper airways of the lungs open by providing a flow of air delivered through a face mask. The air is pressurized by a machine, which delivers alternating levels of positive airway pressure to the face through long plastic hosing.

Central Sleep Apnea – A sleep related disorder in which the effort to breathe is diminished or absent, typically for 10 to 30 seconds, either intermittently or in cycles, and is usually associated with reduction in blood oxygen saturation.

Chronic Obstructive Pulmonary Disease (COPD) – A group of progressive diseases with chronic inflammation and obstruction/constriction of the small airways leading to severe dyspnea, reduced health-related quality of life, and high mortality rates. The disease is classified as mild, moderate, or severe. Examples of COPD include chronic bronchitis, emphysema, bronchiectasis, and cystic fibrosis.

$Fi0_2$ – The fractional concentration of oxygen delivered for inspiration or the percent of oxygen a patient is inhaling. A 'prescribed Fi02' is the oxygen concentration the patient normally breathes when not undergoing testing to qualify for coverage of a Respiratory Assist Device (RAD).

FEV1 – The forced expired volume in one second.

FVC – The forced vital capacity.

Hypopnea – An abnormal respiratory event lasting at least ten seconds and is associated with at least a 30% reduction in thoracoabdominal movement or airflow compared to baseline, and at least a 4% decrease in oxygen saturation.

Hypoventilation Syndrome/Obesity Hypoventilation Syndrome – A chronic condition in which obesity (body mass index greater than or equal to 30 kg/m2) and chronic hypoventilation during waking hours are combined. Hypoventilation is defined as insufficient ventilation leading to hypercapnia, which is an increase in the partial pressure of carbon dioxide as measured by arterial blood gas analysis. This condition can result in pulmonary hypertension, cor pulmonale, and probable early mortality. The condition is associated with respiratory, metabolic, hormonal, and cardiovascular impairments.

Noninvasive Positive Pressure Ventilation/Assistance (NIPPV/NPPV/NPPRA) – A form of ventilatory assistance delivered via a noninvasive interface (i.e., full face mask, nasal mask/pillows), as opposed to invasive ventilation that is delivered through an endotracheal tube or tracheostomy.

Obstructive Sleep Apnea – The most common form of sleep apnea caused by complete or partial obstruction of the upper airway. It is characterized by repetitive episodes of shallow or paused breathing during sleep, despite the effort to breathe, and is usually associated with a reduction of blood oxygen saturation.

PaO_2 – The level of oxygen in the blood obtained via arterial blood gas.

Positive Airway Pressure (PAP) – A mode of mechanical respiratory ventilation.

Respiratory Assist Devices (RADs) – Devices that are capable of operating in numerous modes, from basic continuous positive pressure to traditional pressure and volume ventilator modes.

Restrictive Thoracic Disorders – Lung diseases that are a category of extra-pulmonary, pleural or parenchymal respiratory diseases that restrict lung expansion, resulting in a decreased lung volume, an increased work of breathing, and inadequate ventilation and/or oxygenation. Examples of Restrictive Thoracic Disorders include amyotrophic lateral sclerosis, Duchenne muscular dystrophy, myasthenia gravis, post-polio syndrome, spinal cord injuries, and severe thoracic cage abnormality (e.g., kyphoscoliosis).

SpO_2 – Measurement of how saturated hemoglobin is with oxygen.

PROCEDURES

Coverage shall be provided per this policy for patients who have been diagnosed with:

A. Restrictive Thoracic Disorders; OR
B. Severe Obstructive Pulmonary Disease (COPD); OR
C. Central Sleep Apnea; OR
D. Obstructive Sleep Apnea; OR
E. Hypoventilation Syndrome

1. The following medical necessity criteria for a condition above must be met:
   A. **Restrictive Thoracic Disorders**
      Bi-level PAP devices *without* a backup featured (E0470) will be considered medically necessary when:
      1) The patient's COPD does not contribute significantly to the patient's pulmonary limitation; AND
      2) The patient has a progressive neuromuscular disease (such as amyotrophic lateral sclerosis, etc.) or a severe thoracic cage abnormality (such as post-thoracoplasty for tuberculosis, etc.); AND
      3) The patient has symptoms of sleep-associated hypoventilation (nocturnal hypoxemia), such as daytime hypersomnolence, excessive fatigue, dyspnea, morning headache, cognitive dysfunction, etc.; AND
      4) The patient has clinically significant hypoxemia, as indicated by the following:
         a. Arterial blood gas $PaC0_2$ is greater than or equal to 45 mmHg, performed while the patient is awake and breathing their prescribed $Fi0_2$ (fractional inspired oxygen concentration); OR
         b. Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes of nocturnal recording time (minimum recording time of two hours), performed while breathing the patient's prescribed $Fi0_2$; OR
         c. For progressive neuromuscular diseases:
            1. The maximal inspiratory pressures are less than 60 cm H_20; OR
            2. Forced vital capacity (FVC) less than 50% of predicted.

In order for a bi-level PAP device with a backup feature (E0471) to be covered, the medical record must contain documentation that the bi-level PAP device without a backup rate was ineffective.

B. **Severe Chronic Obstructive Pulmonary Disease (COPD)**

Coverage criteria for E0470, a bi-level pressure respiratory assist device *without* a backup rate feature using a noninvasive interface (intermittent assist device with continuous positive pressure) may considered medically necessary when the following criteria are met:

1) The patient has symptoms of sleep-associated hypoventilation (nocturnal hypoxemia/hypercapnia), such as daytime hypersomnolence, excessive fatigue, dyspnea, morning headache, cognitive dysfunction, etc.; AND
2) Arterial blood gas $PaC0_2$ of 52 mmHg or greater, done while awake and breathing using the patient's prescribed $Fi0_2$; AND
3) Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative five minutes of nocturnal recording time (minimum recording time of two hours), done while breathing oxygen at 2 LPM or the prescribed $Fi0_2$, whichever one is higher; AND
4) Documentation related to recurrent hospitalizations for hypercapnic respiratory failure (greater than or equal to two admissions within a twelve-month period); AND
5) Prior to initiating NPPV therapy, sleep apnea and treatment with a continuous positive pressure device (CPAP) has been considered and ruled out.

Documented formal sleep apnea testing is not needed if there is sufficient information in the medical record that demonstrates that the patient does not suffer from some form of sleep apnea as the primary cause of awake hypercapnia or nocturnal arterial oxygen desaturation.

If all of the above criteria are met for patients with COPD, the E0470 device and related accessories will be covered as medically necessary. If all of the above criteria are not met, requests for the E0470 device and related accessories will require case-by-case review.

The E0471 device (respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface) is considered medically necessary for patients with COPD when the patient has demonstrated at least two months of compliant use of E0471 (expected use on average of four hours in a 24-hour time period) and one of the following:

1) For those patients who qualified for an E0470 device, an E0471 initiated any time after a period of initial use of an E0470 is covered if an arterial blood gas $PaC0_2$, performed on the patient while awake and on prescribed $Fi0_2$, shows the $PaC0_2$ worsened greater than or equal to 7 mmHG compared to the original result; AND if a past facility polysomnography demonstrated an oxygen saturation less than or equal to 88% for greater than or equal to a cumulative five minutes of nocturnal recording (minimum recording time of two hours) while using the E0470 device that is not caused by obstructive upper airway events; OR
2) For patients who qualified for an E0470 device, the E0471 will be covered if, at a time no sooner than 61 days after the initial issue of the E0470 device, when an arterial blood gas $PaC0_2$ is done while awake and the patient is breathing with prescribed $Fi0_2$, still remains greater than or equal to 52 mmHg; AND sleep oximetry while breathing with the E0470 demonstrates oxygen saturation less than or equal to 88% for greater

than or equal to a cumulative of five minutes of nocturnal recording time (minimum recording time of two hours), done while breathing oxygen at 2 LPM of the prescribed $Fi0_2$, whichever is higher.

C. **Central Sleep Apnea or Complex Sleep Apnea**

In order to provide noninvasive positive pressure ventilation device (either the E0470 or the E0471) for a patient with Central Sleep Apnea, the following criteria must be met as confirmed by a polysomnography:

1) An AHI greater than 5; AND
2) The sum total of central apneas or hypopneas is greater than 50% of the total apneas/hypopneas; AND
3) Central apneas or hypopneas greater than 50% of the total apneas/hypopneas; AND
4) Central apneas or hypopneas greater than or equal to 5 times per hour; AND
5) The presence of at least one of the following: sleepiness, difficulty initiating or maintaining sleep, frequent awakenings, or no-restorative sleep, awakening short of breath, snoring or witnessed apneas; AND
6) There is no evidence of daytime or nocturnal hypoventilation.

If all of the criteria above are met, then E0470 or E0471 and related supplies will be considered medically necessary.

D. **Obstructive Sleep Apnea (OSA)**

Noninvasive positive pressure ventilation device (E0470) may be considered medically necessary when the following criteria are met:

1) Have been diagnosed with OSA; AND
2) Have failed medical management; AND
3) A CPAP has been tried and been proven ineffective or is not tolerated based on therapeutic trial in either a facility or during a three-month trial in the home setting.

If the criteria are met, an E0470 Respiratory Assist Device (RAD) will be considered medically necessary. The use of an E0471 Respiratory Assist Device (RAD) has not been proven to be of value for patients with a primary diagnosis OSA (G47.33) and will be considered not medically necessary.

Intraoral devices

If the patient is not able to tolerate a positive pressure device or the use of such a device is contraindicated, a custom-made oral appliance for the treatment of OSA may be considered medically necessary. Please refer to Highmark Health Options medical policy MP-039-MD-DE: Custom Made Oral Appliances in the Treatment of Obstructive Sleep Apnea (OSA).

E. **Hypoventilation Syndrome**

Coverage for E0470 may be considered medically necessary when the following criteria are met:

1) Arterial blood gas $PaC0_2$ is greater than 45 mmHg done while the patient is awake and breathing the prescribed $Fi0_2$; AND
2) There is a 70% or greater spirometry FEV1/FVC; AND

3) Arterial blood gas $PaC0_2$ has worsened greater than or equal to 7 mmHg compared to the original results outlined in criterion A, performed during sleep or immediately upon wakening while breathing the patient's prescribed $Fi0_2$; OR
4) Polysomnography or home sleep-study documents an oxygen saturation less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive upper airway events (e.g., AHI less than 5).

If the above criteria are met, the E0470 device and related supplies will be approved as medically necessary.

Coverage for E0471 is available for patients when criteria A & B AND the following criteria are met:

1) If a covered E0470 Respiratory Assist Device (RAD) is currently being used; AND
2) FEV1/FVC per spirometry is greater than or equal to 70%; AND
3) Arterial blood gas $PaC0_2$, performed while the patient is awake and breathing the prescribed $Fi0_2$, has worsened greater than or equal to 7 mmHg compared to the arterial blood gas result performed for the qualifying criteria for the E0470 device; OR
4) A polysomnography or home sleep study demonstrates an oxygen saturation less than or equal to 88% for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive airway events (e.g., AHI less than 5 while using an E0470 device).
5) If all the above criteria are met, the E0471 device and related supplies are considered medically necessary.

2. For continuation of coverage of either the E0470 or E0471 there must be:
   A re-evaluation after three months of therapy to assess the continued medical necessity for NPPV.

   Medical records must contain physician documentation that the patient has been compliant with the device in a face-to-face clinical evaluation (an average of four hours per 24-hour period during a 30 consecutive-day period) and that the patient is benefiting from the therapy. Compliance documentation will be reviewed on an individual basis for situations in which the patient has been in an accident, change in physical status, surgery, etc.

3. Pediatric Use
   Requests for the pediatric use of bi-level Respiratory Assist Devices will be considered on an individual case basis and require, at a minimum, a complete evaluation by and a recommendation from a specialist such as a pediatric pulmonologist or cardiothoracic surgeon.

4. Contraindications for NPPV Therapy:
   A. Inability to fit or tolerate noninvasive interface
   B. Facial trauma or facial, esophageal, or gastric surgery
   C. Cardiovascular instability
   D. Excessive and/or viscous secretions
   E. Recent gastro-esophageal surgery
   F. Severely impaired mental status
   G. Reduced consciousness

5. Noninvasive Respiratory Assist Devices are considered not medically necessary.
    - This policy excludes the use of CPAP, non-invasive positive pressure ventilators, noninvasive ventilation in pediatric populations, and noninvasive negative pressure ventilation.
    - Noninvasive respiratory assist devices are not covered for indications other than those listed above, because the scientific evidence has not been established.

6. All equipment and accessories must be prescribed by a physician with detailed written orders. Accessories requested for greater than the outlined quantity limits will need to be reviewed for medical necessity. Refer to Attachment C: Table of Accessories and Quantities Limits.
    A. Either a heated or non-heated humidifier (E0561, E0562) is considered medically necessary for use with NPPV.
    B. Compliance-monitoring equipment is considered an integral component of the function of the device and is not eligible for separate reimbursement.
    C. There is no additional payment for the liners (A9999) used with the RADs, which are made of cloth, silicone, or other materials and are placed between the skin and the mask interfaces because they are not medically necessary.

7. Post-payment Audit Statement
   The medical record should include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

8. Place of Service
   The place of service for the administration to occur is in an outpatient setting

9. Length of Coverage
   Length of initial and continuation of coverage is three months. For coverage beyond the initial (3) months of therapy, medical necessity of continued coverage of these devices must occur within 61 to 90 days from the date the therapy was initiated.

GOVERNING BODIES APPROVAL

The FDA has approved several types of single level continuous positive airway pressure (CPAP), auto-adjusting CPAP RADs, and bi-level positive pressure (PAP) RADs for obstructive sleep apnea and/or respiratory insufficiency caused by central and/or mixed apneas and periodic breathing.

CODING REQUIREMENTS

Procedure Codes

CPT/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, with back-up rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0561	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0562	Humidifier, heated, used with positive airway pressure device
S8186	Swivel adaptor

Table 1: Diagnosis Codes for E0471

ICD-10 Codes	Description
B91	Sequelae of poliomyelitis
E66.2	Morbid (severe) obesity with alveolar hypoventilation
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor Neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.22	Progressive bulbar palsy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Post-polio syndrome
G47.30	Sleep apnea, unspecified
G47.31	Primary central sleep apnea
G47.34	Idiopathic sleep related non-obstructive alveolar hypoventilation
G47.35	Congenital central alveolar hypoventilation syndrome
G47.36	Sleep related hypoventilation in conditions classified elsewhere
G47.37	Central sleep apnea in conditions classified elsewhere
G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.5	Neuralgic amyotrophy
G54.6	Phantom limb syndrome with pain
G54.7	Phantom limb syndrome without pain
G54.8	Other nerve root and plexus disorders
G54.9	Nerve root and plexus disorder, unspecified
G55	Nerve root and plexus compressions in diseases classified elsewhere
G70.00	Myasthenia gravis without acute exacerbation

G70.01	Myasthenia gravis with acute exacerbation
G70.1	Toxic myoneural disorders
G70.2	Congenital and developmental myasthenia
G70.80	Lambert-Eaton syndrome, unspecified
G70.81	Lambert-Eaton syndrome in disease classified elsewhere
G70.89	Other specified myoneural disorders
G70.9	Myoneural disorder, unspecified
G71.0	Muscular dystrophy
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenital
G71.13	Myotonia chondrodystrophy
G71.14	Drug induced myotonia
G71.19	Other specified myotonic disorders
G71.2	Congenital myopathies
G71.3	Mitochondrial myopathy, not elsewhere classified
G71.8	Other primary disorders of muscles
G71.9	Primary disorder of muscle, unspecified
G72.0	Drug-induced myopathy
G72.1	Alcoholic myopathy
G72.2	Myopathy due to other toxic agents
G72.3	Periodic paralysis
G72.41	Inclusion body myositis
G72.49	Other inflammatory and immune myopathies, not elsewhere classified
G72.81	Critical illness myopathy
G72.89	Other specified myopathies
G72.9	Myopathy, unspecified
G73.1	Lambert-Eaton syndrome in neoplastic disease
G73.3	Myasthenic syndromes in other diseases classified elsewhere
G73.7	Myopathy in diseases classified elsewhere
G93.3	Postviral fatigue syndrome
J40	Bronchitis, not specified as acute or chronic
J41.0	Simple chronic bronchitis
J41.1	Mucopurulent chronic bronchitis
J41.8	Mixed simple and mucopurulent chronic bronchitis
J42	Unspecified chronic bronchitis
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J43.9	Emphysema, unspecified
J44.0	Chronic obstructive pulmonary disease with acute lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with acute exacerbation
J47.9	Bronchiectasis, uncomplicated

J67.0	Hypersensitivity pneumonitis due to organic dust, Farmer's lung
J67.1	Hypersensitivity pneumonitis due to organic dust, Bagassosis
J67.2	Hypersensitivity pneumonitis due to organic dust, Bird fancier's lung
J67.3	Hypersensitivity pneumonitis due to organic dust, Suberosis
J67.4	Hypersensitivity pneumonitis due to organic dust, Maltworker's lung
J67.5	Hypersensitivity pneumonitis due to organic dust, Mushroom-worker's lung
J67.6	Hypersensitivity pneumonitis due to organic dust, Maple-bark-stripper's lung
J67.7	Hypersensitivity pneumonitis due to organic dust, Air conditioner and humidifier lung
J67.8	Hypersensitivity pneumonitis due to organic dust, Hypersensitivity pneumonitis due to other organic dusts
J67.9	Hypersensitivity pneumonitis due to organic dust, Hypersensitivity pneumonitis due to unspecified organic dust
J80	Acute respiratory distress syndrome
J96.00	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapinia
J96.10	Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.11	Chronic respiratory failure with hypoxia
J96.12	Chronic respiratory failure with hypercapnia
J96.20	Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.21	Acute and chronic respiratory failure with hypoxia
J96.22	Acute and chronic respiratory failure with hypercapnia
J96.90	Respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.91	Respiratory failure, unspecified with hypoxia
J96.92	Respiratory failure, unspecified with hypercapnia
J98.4	Other disorders of lung
M41.00	Infantile idiopathic scoliosis, site unspecified
M41.02	Infantile idiopathic scoliosis, cervical region
M41.03	Infantile idiopathic scoliosis, cervicothoracic region
M41.04	Infantile idiopathic scoliosis, thoracic region
M41.05	Infantile idiopathic scoliosis, thoracolumbar region
M41.06	Infantile idiopathic scoliosis, lumbar region
M41.07	Infantile idiopathic scoliosis, lumbosacral region
M41.08	Infantile idiopathic scoliosis, sacral and sacrococcygeal region
M41.112	Juvenile idiopathic scoliosis, cervical region
M41.113	Juvenile idiopathic scoliosis, Juvenile, cervicothoracic region
M41.114	Juvenile idiopathic scoliosis, thoracic region
M41.115	Juvenile idiopathic scoliosis, thoracolumbar region
M41.116	Juvenile idiopathic scoliosis, lumbar
M41.117	Juvenile idiopathic scoliosis, lumbosacral region
M41.119	Juvenile idiopathic scoliosis, site unspecified
M41.122	Adolescent idiopathic scoliosis, cervical region
M41.123	Adolescent idiopathic scoliosis, cervicothoracic region
M41.124	Adolescent idiopathic scoliosis, thoracic region
M41.125	Adolescent idiopathic scoliosis, thoracolumbar region
M41.126	Adolescent idiopathic scoliosis, lumbar region
M41.127	Adolescent idiopathic scoliosis, lumbosacral region

M41.129	Adolescent idiopathic scoliosis, site unspecified
M41.20	Other idiopathic scoliosis, site unspecified
M41.22	Other idiopathic scoliosis, cervical region
M41.23	Other idiopathic scoliosis, cervicothoracic region
M41.24	Other idiopathic scoliosis, thoracic region
M41.25	Other idiopathic scoliosis, thoracolumbar region
M41.26	Other idiopathic scoliosis, lumbar region
M41.27	Other idiopathic scoliosis, lumbosacral region
M41.30	Thoracogenic scoliosis, site unspecified
M41.34	Thoracogenic scoliosis, thoracic region
M41.35	Thoracogenic scoliosis, thoracolumbar region
M41.40	Neuromuscular scoliosis, site unspecified
M41.41	Neuromuscular scoliosis, occipito-atlanto-axial region
M41.42	Neuromuscular scoliosis, cervical region
M41.43	Neuromuscular scoliosis, cervicothoracic region
M41.44	Neuromuscular scoliosis, thoracic region
M41.45	Neuromuscular scoliosis, thoracolumbar region
M41.46	Neuromuscular scoliosis, lumbar region
M41.47	Neuromuscular scoliosis, lumbosacral region
M41.50	Other secondary scoliosis, site unspecified
M41.52	Other secondary scoliosis, cervical region
M41.53	Other secondary scoliosis, cervicothoracic region
M41.54	Other secondary scoliosis, thoracic region
M41.55	Other secondary scoliosis, thoracolumbar region
M41.56	Other secondary scoliosis, lumbar region
M41.57	Other secondary scoliosis, lumbosacral region
M41.80	Other forms of scoliosis, site unspecified
M41.82	Other forms of scoliosis, cervical region
M41.83	Other forms of scoliosis, cervicothoracic region
M41.84	Other forms of scoliosis, thoracic region
M41.85	Other forms of scoliosis, thoracolumbar region
M41.86	Other forms of scoliosis, lumbar region
M41.87	Other forms of scoliosis, lumbosacral region
M41.9	Scoliosis unspecified
M95.4	Acquired deformity of chest and rib
M96.5	Postradiation scoliosis
R06.00	Dyspnea, unspecified
R06.09	Other forms of dyspnea
R06.3	Periodic breathing
R06.81	Apnea, not elsewhere classified
R06.83	Snoring
R06.89	Other abnormalities of breathing
R09.02	Hypoxemia
R53.1	Weakness
R53.81	Other malaise

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

Table of Accessories and Quantities Limits

Code	Quantity	Descriptions
A4604	1 per 3 months (4 per calendar year)	Tubing with integrated heating element for use with positive airway pressure device
A7027	1 per 3 months (4 per calendar year)	Combination oral/nasal mask, used with continuous positive airway pressure device, each
A7028	2 per 1 month (24 per calendar year)	Oral cushion for combination oral/nasal mask, replacement only, each
A7029	2 per 1 month (24 per calendar year)	Nasal pillows for combination oral/nasal mask, replacement only, pair
A7030	1 per 3 months (4 per calendar year)	Full face mask used with positive airway pressure device, each
A7031	1 per 1 month (12 per calendar year)	Face mask interface, replacement for full face mask, each
A7032	2 per 1 month (24 per calendar year)	Cushion for use on nasal mask interface, replacement only, each
A7033	2 per 1 month (24 per calendar year)	Pillow for use on nasal cannula type interface, replacement only, pair
A7034	1 per 3 months (4 per calendar year)	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035	1 per 6 months (2 per calendar year)	Headgear used with positive airway pressure device
A7036	1 per 6 months (2 per calendar year)	Chinstrap used with positive airway pressure device
A7037	1 per 3 months (4 per calendar year)	Tubing used with positive airway pressure device
A7038	2 per 1 month (24 per calendar year)	Filter, disposable, used with positive airway pressure device
A7039	1 per 6 months (2 per calendar year)	Filter, non-disposable, used with positive airway pressure device
A7046	1 per 6 months (2 per calendar year)	Water chamber for humidifier, used with positive airway pressure device, replacement, each
A7044	1 per 3 months (4 per calendar year)	Oral interface used with positive airway pressure device, each
A7045	1 per 3 months (4 per calendar year)	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only
E0561	Rental only	Humidifier, non-heated, used with positive airway pressure devices
E0562	Rental only	Humidifier, heated, used with positive airway pressure devices

POLICY SOURCE(S)

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Policy History

Date	Activity
02/17/2016	Policy approved at QI/UM Meeting
07/05/2016	Provider effective date
03/14/2017	Revisions: multiple verbiage changes, typographical errors corrected, added reference to Intraoral Appliances coverage; corrected Operational Guidelines to read preservice instead of post-service; added Policy History box; WVFH disclaimer update; removed groupings of codes and entered individual code with descriptions and removed several coding ranges as not applicable
08/09/2017	Added Disclaimer Statement in opening of medical policy. Issue Date added to opening policy box, Procedure and Diagnosis tables retitled to read "Covered" procedure and diagnosis codes; Page 5: Eligible Diagnosis table created for E0471 and separate table for remaining procedure codes in Attachment B. Operational Guidelines updated. Added HCPCS codes for humidifier, E0561 and E0562.
12/13/2017	Clinical Review: No changes
01/22/2018	Revised verbiage in the Operational Guidelines so that the Attachments are referenced correctly. Added 3rd table to Attachment B for codes E0601 & 94660. Added code A7045 to Attachment C Table of Accessories and Quantities Limit
03/13/2018	QI/UM Committee Review Approval
04/25/2018	Revision: Removed the word 'Covered' from the procedure and diagnosis code tables in Attachments A & B
05/15/2018	New Provider Effective Date
12/11/2018	Annual Review Revisions: Added language to exclude CPAP from the policy; Added length of coverage language which also mentioned in #2; Removed codes E0601 (CPAP) and 94660 from the policy and deleted Table 3 under Attachment B; Removed operational guidelines referring to CPAP; Added references; removed the hyperlinks from all references.
12/11/2018	QI/UM Committee Review Approval
02/18/2019	New Provider Effective Date