Priority Health	BILLING POLICY No. 020

POSITIVE AIRWAY PRESSURE (PAP) DEVICES FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Effective date: June 19, 2025 **Date of origin: Aug. 2024**	**Review dates: 11/2024, 2/2025, 6/2025, 01/2026**

APPLIES TO

This policy applies to commercial and Medicare plans. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

For Medicaid / Healthy Michigan plans, see the Medicaid Provider Manual.

DEFINITION

In alignment with the Centers for Medicare and Medicaid Services (CMS) and local coverage determinations (LCDs), maximum allowable quantities for positive airway pressure (PAP) supplies are outlined below. These are defined quantities based on standards identified as reasonable and necessary for the usual member.

MEDICAL POLICY

- Sleep Apnea: Obstructive & Central (#91333)

POLICY SPECIFIC DETAILS

Billing details

PAP devices are covered under the durable medical equipment (DME) benefit and are considered capped rentals. See our Durable Medical Equipment (#91110) medical policy for details regarding capped rentals.

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 backup 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

Accessories for PAP devices are separately reimbursable when initially ordered and when replaced. These accessories are subject to the following quantity limits. Any greater quantity will be denied.

A4604	1 per 3 months
A7027	1 per 3 months
A7028	2 per 1 month
A7029	2 per 1 month
A7030	1 per 3 months
A7031	1 per 1 month
A7032	2 per 1 month

A7033	2 per 1 month
A7034	1 per 3 months
A7035	1 per 6 months
A7036	1 per 6 months
A7037	1 per 3 months
A7038	2 per 1 month
A7039	1 per 6 months
A7046	1 per 6 months

Capped rental devices should be billed with a date span that encompass the month being billed for the DME rental. The “from” date will identify the date the item was furnished to the member, and the “to” date should reflect the last date of the date span for the item or supply. Accurately defining this date span will allow for accurate processing of the claim.

- Claims with dates of service that overlap will result in a denial.
- Supplies that are billed for a date span should also follow the “From” / “To” date guidelines.

Documentation requirements

Documentation may be requested from the ordering provider indicating medical necessity for treatment of Obstructive Sleep Apnea (OSA). Documentation must include:

- A sleep test ordered by treating provider
- Results of the sleep test indicating medical necessity

Place of service

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Modifiers

- **RR Rental**: Use the RR modifier when DME is to be rented
- **KX (Commercial, Medicaid)**: Appended to indicate that medical necessity has been met per medical policy criteria. Claims without KX modifier will deny as non-payable per medical policy.
- **KX (Medicare)**: Appended to indicate that medical necessity has been met per medical policy criteria.
- **GA & GZ (Medicare)**: Appended to indicate that all coverage criteria haven’t been met per policy and there’s an expectation of a reasonable and necessary denial. GA indicates an Advanced Beneficiary Notice (ABN) has been obtained and GZ indicates no ABN has been obtained.
- Medicare claim lines billed without KX, GA or GZ will be denied.

DISCLAIMER

Priority Health’s billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member’s benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member’s benefit plan or authorization isn’t being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn’t a guarantee of payment when proper billing and coding requirements or adherence to our policies aren’t followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services

rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Nov. 11, 2024	Added "Place of service" section
Feb. 5, 2025	Added "Disclaimer" section

June 19, 2025	• Clarification: Capped rental devices should be billed with a date span that encompass the month being billed for the DME rental. The "from" date will identify the date the item was furnished to the member and the "to" date should reflect the last date of the date span for the item or supply. Accurately defining this date span will allow for accurate processing of the claim
	  ○ Claims with dates of service that overlap will result in a denial.
	  ○ Supplies that are billed for a date span should also follow the "From" / "To" date guidelines.
	• Addition: RR Rental (use the RR modifier when DME is to be rented)

Jan 23, 2026	Review no changes