VERMONT
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The Department of Vermont Health Access Supplement to InterQual® Criteria

Note: The Department of Vermont Health Access (DVHA) covers the below service(s) in alignment with InterQual® criteria AND must also ensure accordance with applicable Vermont Health Care Rules when making coverage determinations (e.g., when considering medical necessity, the DVHA must ensure that the service is the least costly, appropriate health service that is available). Therefore, information as outlined below may be requested in addition to that included in InterQual® criteria.

To access InterQual® criteria, please log into your account at the Vermont Medicaid Portal, go to secure options and click on InterQual® Solution from the dropdown menu.

Subject: Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea in the Home Setting
Last Review: June 26, 2024
Past Revisions: N/A

***Please note: Most current content changes will be highlighted in yellow.**

Description of Service or Procedure

Positive airway pressure (PAP) devices for the treatment of obstructive sleep apnea as defined by CMS includes:

- Bi-level positive airway pressure (BiPAP) without backup feature
- Continuous positive airway pressure (CPAP) or auto-titrating positive airway pressure (APAP) device

The American Academy of Sleep Medicine guidelines for the treatment of adult obstructive sleep apnea (OSA) with positive airway pressure (2019) include the following good practice statements:

- Treatment of OSA with PAP therapy should be based on a diagnosis of OSA established using objective sleep apnea testing.
- Adequate follow-up, including troubleshooting and monitoring of objective efficacy and usage data to ensure adequate treatment and adherence, should occur following PAP therapy initiation and during treatment of OSA.

In addition to InterQual® criteria, the DVHA aligns criteria for coverage of PAP devices with Medicare coverage guidance, unless otherwise noted.

See CMS LCD L33718 on Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea.

Disclaimer

Coverage is limited to that outlined in Medicaid Rule or Health Care Administrative Rules that pertain to the member's aid category. Prior Authorization (PA) is only valid if the member is eligible for the applicable item or service on the date of service.

Medicaid Rule

Medicaid and Health Care Administrative Rules can be found at https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules

4.101 Medical Necessity for Covered Services
4.104 Medicaid Non-Covered Services
4.106 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
4.209 Durable Medical Equipment

Coverage Position

PAP may be covered for members:

- When the device is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice as described on the Vermont Office of Professional Regulation's website*, Statute, or rule who is knowledgeable regarding PAP and who provides medical care to the member AND
- When the clinical criteria below are met.

* Vermont's Office of Professional Regulation's website: https://sos.vermont.gov/opr/

Coverage Criteria

PAP devices may be covered for members who have a diagnosis of any of the following:

1. OSA is determined either at initial polysomnography or during an unattended (unsupervised) home sleep study.
2. Complex sleep apnea members who have demonstrated obstructive sleep apnea either at initial polysomnography or during an unattended (unsupervised) home sleep study.
3. Obesity Hypoventilation Disorder
4. Restrictive Thoracic Disorders such as, polio, amyotrophic lateral sclerosis, chest wall deformities, spinal cord injury, and neuro-myo-dystrophies
5. Severe COPD with hypercapnia and low oxygen saturations
6. Central Sleep Apnea

Special Consideration

- Adaptive servo-ventilation (ASV) for adults may be superior to bi-level -ST for suppressing sleep disordered breathing, specifically central sleep apnea secondary to chronic opioid use. Or patient's exhibiting combinations of central and obstructive sleep apnea
- If the member fails the 12-week trial, they may requalify for a PAP device if the following conditions are met:
    - The member has a reevaluation by the treating provider to determine cause of the failure to respond to therapy, and
    - The member undergoes a repeat sleep study in a facility-based setting. This may be a diagnostic, titration or split-night study.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Vermont Medicaid will provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid members under age 21.

Please note, Vermont Medicaid Clinical Criteria is reviewed based on available literature, evidence- based guidelines/standards, Medicaid rule and policy, and Medicare coverage determinations that may be appropriate to incorporate when applicable.

Clinical criteria for repeat service or procedure

Replacement device(s) is covered when:

- According to CMS LCD L33718
    - If a PAP device is replaced during the 5-year reasonable useful lifetime (RUL) because of loss, theft, or irreparable damage due to a specific incident, there is no requirement for a new clinical evaluation, sleep test, or trial period.
    - If a PAP device is replaced following the 5-year RUL, there must be a face to face or telehealth evaluation by the provider treating the Obstructive Sleep Apnea (OSA) treating physician that documents that the beneficiary continues to use and benefit from the PAP device. There is no requirement for a new sleep test or trial period.

See the DME limitation list on the VT Medicaid Portal under Provider Resources at http://vtmedicaid.com/#/resources.

Type of service or procedure covered

Note: To be considered for continued use, adherence to therapy is defined as use greater than or equal to four (4) hours per night for a minimum of 21 nights (70% of nights) during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. No prior authorization is required.

Type of service or procedure not covered (this list may not be all inclusive)

Bi-level positive airway pressure (BiPAP) with backup feature: bi-level positive airway pressure device with back-up rate (E0471) is not reasonable and necessary if the primary diagnosis is OSA per Medicare Guidelines. For bilevel PAP with a backup rate or servo-controller feature to

be covered, there must be medical record evidence that bilevel PAP without a backup rate is ineffective**.**

Coding guidelines

Please see the Medicaid Portal at http://vtmedicaid.com/#/feeSchedule for fee schedules, code coverage, and applicable requirements.

Billing Information

- PAP devices are covered through the capped rental program. They must be billed with the RR modifier, and they are paid in 10 monthly installments.
- The DVHA will follow Medicare guidelines for the maximum amount of supply items expected to be reasonable and necessary.
- Regardless of utilization, a supplier must not dispense more than a three (3) - month quantity at a time.

References

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