Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Positive Airway Pressure (PAP) Devices for Tufts Health RITogether and Tufts Health One Care

Effective: September 1, 2026

Prior Authorization Required If REQUIRED, submit supporting clinical documentation (electronically recommended or by fax)	Yes ☒ No ☐
Notification Required	Yes ☐ No ☒

Applies to:

- Tufts Health RITogether
- Tufts Health One Care

We recommend submitting prior authorization electronically. If you opt to submit prior authorization requests via fax, please refer to this reference chart for the appropriate fax number (varies by product).
For details on all our products, please visit the Our Plans page on our provider website. For additional Prior Authorization and Notification details on other lines of business not listed on our Medical Necessity Guidelines page, please also reference our Prior Authorization Resources page.

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

For Tufts Health Plan Members:

To obtain InterQual® SmartSheets™"

- **Tufts Health Plan Commercial Plan products:** If you are a registered Tufts Health Plan provider click here to access the Provider Website. If you are not a Tufts Health Plan provider, please click on the Provider Log-in and follow instructions to register on the Provider website or call Provider Services at 888-884-2404
- **Tufts Health Public Plans products:** InterQual® SmartSheet(s) available as part of the prior authorization process

Tufts Health Plan requires the use of current InterQual® Smartsheet(s) to obtain prior authorization.

In order to obtain prior authorization for procedure(s), choose the appropriate InterQual® SmartSheet(s) listed below. The completed SmartSheet(s) must be sent to the applicable fax number indicated above, according to Plan

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and documentation included in the Medicare manuals and MassHealth Medical Necessity Determinations are the basis for coverage determinations where available. For **Tufts Health One Care** plan Members, the following criteria is used: LCD - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718) (cms.gov) and Article - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article (A52467) (cms.gov)

The Plan requires the use of the following InterQual® Subsets or SmartSheets to obtain prior authorization for Positive Airway Pressure Devices:

1. Continuous Positive Airway Pressure (CPAP) Device
2. Respiratory Assist Device, Bi-level Pressure with Backup Rate
3. Respiratory Assist Device, Bi-level Pressure without Backup Rate

Plan Modifications to InterQual:

Documentation of an authorized sleep study, completed within the previous 24 months, will be required to determine the

need for continued positive airway pressure treatment if:

1. Previous sleep study is not available or
2. Results of previous sleep study do not clearly establish a diagnosis of obstructive or central sleep apnea which will benefit from PAP treatment or
3. Clinical documentation suggests a change in clinical status (e.g., cardiac, pulmonary, neuromuscular condition, substantial weight loss, upper airway surgery) since previous sleep study.

Authorization of a Replacement of or Repair of Positive Airway Pressure Device

The Plan does not cover replacement devices necessary due to loss, theft, or irreparable damage for RITogether Members. Please refer to Member Materials for confirmation of coverage

- For Tufts Health One Care Members, replacement devices may be authorized due to loss, theft, or irreparable damage

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

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)
E0601	Continuous positive airway pressure (CPAP) device

References:

1. Commonwealth of Massachusetts Mass Health Provider Manual Series, Durable Medical Equipment, 130 CMR 427.000: Oxygen and Respiratory Therapy Equipment. Accessed May 10, 2023. Section (mass.gov)
2. Executive Office of Health and Human Services, State of Rhode Island. Coverage Guidelines for Durable Medical Equipment. Accessed May 10, 2023. (ri.gov)eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx.

Approval And Revision History

August 17, 2020: Effective September 1, 2020, prior authorization for sleep therapy and resupply requests for Tufts Health Direct and Tufts Health Together is managed by eviCore healthcare (eviCore).

Subsequent endorsement date(s) and changes made:

- September 23, 2020: Fax number for Unify updated
- May 19, 2021: Reviewed by IMPAC, renewed without changes
- November 19, 2021: Tufts Health RITogether and Tufts Health Unify added to MNG title.
- April 7, 2022: Template updated
- May 18, 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- May 17, 2023: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes, effective June 5, 2023.
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- December 1, 2023: Reviewed and approved by UM Committee effective January 1, 2024
- May 15, 2024: reviewed by MPAC reviewed without changes effective July 1, 2024
- June 13, 2024: Reviewed by UM Committee, updated LCD links for One Care and InterQual 2024 updates effective July 1, 2024
- June 20, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- April 16, 2025: Reviewed by MPAC, for clarification of limitations, effective June 1, 2025
- May 21, 2025: Reviewed by MPAC for 2025 InterQual update effective July 1, 2025
- June 18, 2025: Reviewed by MPAC, annual review no changes, effective August 1, 2025
- May 20, 2026: Reviewed by MPAC for 2026 InterQual Update, effective July 1, 2026
- July 15, 2026: Reviewed by MPAC for annual review, renewed without changes effective September 1, 2026

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.