Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Medical Necessity Guidelines:

Positive Airway Pressure Devices for Sleep Apnea

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:

- Harvard Pilgrim Health Care Commercial products

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 Harvard Pilgrim Health Care Members:

This policy utilizes InterQual® criteria and/or tools, which Harvard Pilgrim may have customized. You may request authorization and complete the automated authorization questionnaire via HPHConnect at www.harvardpilgrim.org/providerportal. In some cases, clinical documentation may be required to complete a medical necessity review. Please submit required documentation as follows:

- Clinical notes/written documentation – via HPHConnect Clinical Upload or secure fax (800-232-0816)

Providers may view and print the medical necessity criteria and questionnaire via HPHConnect for providers (Select Researched and the InterQual® link) or contact the commercial Provider Service Center at 800-708-4414. (To register for HPHConnect, follow the instructions here). Members may access materials by logging into their online account (visit www.harvardpilgrim.org, click on Member Login, then Plan Details, Prior Authorization for Care, and the link to clinical criteria) or by calling Member Services at 888-333-4742.

Overview

Positive airway pressure is a treatment for obstructive sleep apnea, as well as other uses in the critical care setting. Continuous positive airway pressure (CPAP) delivers a constant stream of air that holds the user's airway open. Auto-titrating positive airway pressure (APAP) automatically titrates, or calibrates, the power of its stream based on user breath resistance to deliver the minimum pressure needed to keep the airway open. Bilevel positive airway pressure (BiPAP) alternates between two pressure levels to provide a lower pressure against user exhalations, with some models relying on a breath sensor and others also having a "backup" rate on a timer to switch the pressure when no breath change is detected. Adaptive servo-ventilation positive airway pressure (ASV-PAP) increases the pressure of its stream when it detects signs of central OSA.

Clinical Guideline Coverage Criteria

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

1. Adaptive Servo-Ventilation Positive Airway Pressure Device
2. Auto-titrating Positive Airway Pressure (APAP) Device
3. Continuous Positive Airway Pressure (CPAP) Device

4. Respiratory Assist Device, Bi-Level Pressure Capability, w/Backup Rate Feature, Used w/Noninvasive Interface
5. Respiratory Assist Device, Bi-Level Pressure Capability, w/o Backup Rate Feature, Used w/Noninvasive Interface

Authorization of a Replacement of or Repair to Positive Airway Pressure Devices:

1. The Plan does not cover replacement devices if due to theft, loss, or irreparable damage. Please see member materials for additional information

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
E0601	Continuous positive airway pressure (cpap) device
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)

Approval And Revision History

April 2020: Reviewed by the Integrated Medical Policy Advisory Committee (IMPAC), Medical Necessity Guideline (MNG) created for Harvard Pilgrim Health Care

Subsequent endorsement date(s) and changes made:

- April 2021: Reviewed by Medical Policy Clinical Committee, renewed without changes
- June 2021: Reviewed by MPAC, InterQual 2021 adopted
- July 2022: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- June 21, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Unify name changed to One Care effective January 1, 2024
- May 15, 2024: Reviewed by MPAC for 2024 InterQual Upgrade, effective July 1, 2024
- April 16, 2025: Reviewed by MPAC for clarification of limitation, 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.