WAC 182-552-0400 Respiratory care—Continuous positive airway pressure (CPAP) device and supplies. (1) The medicaid agency covers, without prior authorization, one continuous positive airway pressure (CPAP) device including related supplies, per client, every five years. The CPAP device must have a data card and the client must meet the following clinical criteria:

(a) The client is diagnosed with obstructive sleep apnea (OSA) using a clinical evaluation and a positive attended polysomnogram (PSG) performed in a sleep laboratory or an unattended home sleep test; and

(b) For clients age twenty-one and older:

(i) The client's polysomnogram or home sleep test demonstrates an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) greater than or equal to fifteen events per hour; or

(ii) The client's polysomnogram or home sleep test demonstrates the AHI or RDI is greater than or equal to five and less than or equal to fourteen events per hour with clinical documentation of:

(A) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or

(B) Hypertension, ischemic heart disease, or history of stroke.

(c) For clients age twenty and younger, the clinical criteria is considered met when there is a documented diagnosis of OSA and polysomnography demonstrates an apnea index (AI) or AHI equal to or greater than one and:

(i) Adenotonsillectomy has been unsuccessful in relieving OSA; or

(ii) Adenotonsillar tissue is minimal; or

(iii) Adenotonsillectomy is inappropriate based on OSA being attributable to another underlying cause (e.g., craniofacial anomaly, obesity) or adenotonsillectomy is contraindicated; or

(iv) Family does not wish to pursue surgical intervention.

(2) If a client meets the criteria in subsection (1) of this section but a CPAP device has been tried and proven ineffective, the medicaid agency will cover a bi-level respiratory assist device (RAD) without the back-up rate. Ineffective, in this case, is defined as documented failure to meet therapeutic goals using a CPAP during the titration portion of a facility-based study or during home use despite optimal therapy (i.e., proper mask selection and fitting and appropriate pressure setting).

(3) The AHI is calculated on the average number of events per hour. If the AHI is calculated based on less than two hours of sleep, the total number of recorded events used to calculate the AHI must be at least the number of events that would have been required in a two-hour period (i.e., must reach greater than or equal to thirty events without symptoms or greater than or equal to ten events with symptoms). The medicaid agency pays for an initial three-month rental period for CPAP devices.

(4) The medicaid agency purchases a CPAP device after the three-month rental period when the following documentation of clinical benefit is recorded in the client's file:

(a) A face-to-face clinical reevaluation of the client by the authorized prescriber which documents that symptoms of obstructive sleep apnea are improved; and

(b) A review of objective evidence by the authorized prescriber of the client's adherence to use of the CPAP device. Adherence is defined as use of the CPAP device greater than or equal to four hours

per night on seventy percent of nights during a consecutive thirty-day period anytime during the first three months of initial usage.

(5) The medicaid agency does not pay for a CPAP device when the client is diagnosed with upper airway resistance syndrome (UARS).

(6) The medicaid agency pays for the purchase of a heated humidifier for a CPAP device, once every five years from the date the item was deemed purchased, per client.

(7) Replacement of CPAP device.

(a) The medicaid agency requires prior authorization for the replacement of a CPAP device if the client has had the device for less than five years.

(b) After five years, the client must have a face-to-face evaluation with the treating authorized prescriber that documents that the client continues to use and benefit from the device. The medicaid agency does not require a new PSG (sleep test), trial period, or prior authorization.

(c) Replacement supplies - The medicaid agency pays for replacement supplies for a CPAP device as follows:

(i) Full face mask, limit one every six months;

(ii) Face mask interface for full face mask, limit one every three months;

(iii) Nasal interface (mask or cannula type), with or without head strap, limit one every six months;

(iv) Cushion for use on nasal mask interface, limit one every three months;

(v) Pillow for use on nasal cannula type interface, limit one pair every three months;

(vi) Headgear, chin strap, and tubing with or without integrated heating element, limit one every six months;

(vii) Filters - Disposable, limit two every thirty days;

(viii) Filters - Nondisposable, limit one every six months; and

(ix) Water chamber for humidifier, limit one every six months.

(d) Prior authorization is required if the client does not meet the clinical criteria in this section or if the medicaid agency has purchased a bi-level respiratory assist device for the client within the last five years.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-20-057, § 182-552-0400, filed 10/1/15, effective 11/1/15. Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0400, filed 6/25/12, effective 8/1/12.]