

Continuous Positive Airway Pressure (CPAP) Reason Codes and Statements

May 12, 2022

| Reason Code | CRITERION A |
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| CP000 | The medical record documentation does not contain a clinical evaluation by the treating practitioner. Refer to Local Coverage Determination L33718. |
| CP001 | The medical record documentation does not contain a clinical evaluation by the treating practitioner prior to the sleep test. Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
| CP002 | The clinical evaluation does not include an assessment of the beneficiary for obstructive sleep apnea. Refer to Local Coverage Determination L33718. |

| Reason Code | CRITERION B |
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| CP100 | The medical record documentation does not contain a sleep test. Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
| CP101 | The medical record documentation does not indicate the apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events or the AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or hypertension, ischemic heart disease, or history of stroke. Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
| CP102 (For RAC Reviews) | The medical record documentation does not indicate a diagnosis of obstructive sleep apnea which is based upon a sleep test that meets the Medicare coverage criteria. Refer to National Coverage Determination (NCD) 240.4 & Local Coverage Determination (LCD) L33718. |
| CP103 | The medical record documentation does not include an interpretation of the sleep test. Refer to Local Coverage Determination L33718. |
| CP104 | The medical record documentation does not support hypopneas were calculated based on at least a 4 percent decrease in oxygen saturation. Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
| CP105 | The medical record documentation indicates the apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) was calculated by including respiratory effort related arousals (RERAs). Refer to Local Coverage Determination L33718. |
| CP106 | The medical record documentation indicates the apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is calculated based on less than 2 hours of sleep/recording time and does not meet the total number of required events used to |

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| | calculate the AHI or RDI Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
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| Reason Code | CRITERION C |
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| CP200 | There is no documentation to support the provider of the CPAP device conducted education on the proper use and care of the device. Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |

| Reason Code | CONTINUING COVERAGE |
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| CP300 | The medical record documentation does not contain an in-person clinical re-evaluation by the treating practitioner between the 31st and 91st day after initiating therapy. Refer to Local Coverage Determination L33718. |
| CP301 | The medical record documentation does not indicate the beneficiary is benefitting from PAP therapy and the symptoms of obstructive sleep apnea are improved. Refer to National Coverage Determination (NCD) 240.4 & Local Coverage Determination (LCD) L33718. |
| CP302 | The medical record documentation indicates the in-person clinical re-evaluation occurred prior to the 31st day after initiating therapy. Refer to Local Coverage Determination L33718. |
| CP303 | The medical record documentation does not include objective evidence of adherence defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive 30-day period anytime during the first three months of initial usage. Refer to Local Coverage Determination L33718. |
| CP304 | The medical record documentation does not support the treating practitioner has reviewed the objective evidence of adherence. Refer to Local Coverage Determination L33718. |

| Reason Code | REASONABLE USEFUL LIFETIME (RUL) |
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| CP400 | The medical record documentation does not support there was an in-person evaluation by their treating practitioner prior to replacement of PAP device following the 5-year reasonable useful lifetime (RUL). Refer to Medicare Program Integrity Manual 5.9, Local Coverage Determination L33718 & Policy Article A55426. |
| CP401 | The medical record documentation does not support the beneficiary continues to use and benefit from the PAP device following the 5-year reasonable useful lifetime |

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| | (RUL). Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
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| Reason Code | BENE ENTERING MEDICARE |
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| CP500 | The medical record documentation does not include documentation the beneficiary had a sleep test, prior to fee for service (FFS) Medicare enrollment. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP501 | The medical record documentation does not include documentation the beneficiary had a sleep test, prior to fee for service (FFS) Medicare enrollment that meets Medicare coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of replacement PAP device. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP502 | The medical record documentation lacks support of a sleep test, prior to the beneficiary's fee for service (FFS) Medicare enrollment date. Refer to Local Coverage Determination L33718. |
| CP503 | The medical record documentation does not support the beneficiary had an in-person evaluation by their treating practitioner following enrollment in fee for service (FFS) Medicare and prior to replacement. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP504 | The medical record documentation does not support that following enrollment in fee for service (FFS) Medicare, the beneficiary had an in-person evaluation by their treating practitioner that documents the beneficiary has a diagnosis of obstructive sleep apnea. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP505 | The medical record documentation does not support that following enrollment in fee for service (FFS) Medicare, the beneficiary had an in-person evaluation by their treating practitioner that documents that the beneficiary continues to use PAP device. Refer to Local Coverage Determination L33718 & Policy Article A52467. |

| Reason Code | 12 WEEK TRIAL |
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| CP600 | The medical record documentation does not address the etiology of the failure to respond to PAP therapy. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP601 | The medical record documentation does not include a repeat sleep test. Refer to Local Coverage Determination L33718 & Policy Article A52467. |

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| CP602 | The medical record documentation does not support the repeat sleep test occurred in a facility-based setting. Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718. |
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| Reason Code | ACCESSORIES |
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| CP700 | More than 1 unit per 6 months of A7046 exceeds the usual maximum amount of accessories as it is included in the initial setup and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP701 | A7045 is a replacement item only and therefore not reasonable and necessary with initial setup. Refer to Local Coverage Determination L33718. |
| CP702 | More than one unit per three months of A4604 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP703 | More than one unit per three months of A7027 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP704 | More than two units per one month of A7028 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP705 | More than two units per one month of A7029 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP706 | More than one unit per three months of A7030 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP707 | More than one unit per one month of A7031 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP708 | More than two units per one month of A7032 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718 & Policy Article A52467. |
| CP709 | More than two units per one month of A7033 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718 & Policy Article A52467. |

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| CP710 | More than one unit per three months of A7034 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP711 | More than one unit per six months of A7035 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP712 | More than one unit per six months of A7036 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP713 | More than one unit per three months of A7037 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP714 | More than two units per one month of A7038 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP715 | More than one unit per six months of A7039 exceeds the usual maximum amount of accessories and is therefore not reasonable and necessary. Refer to Local Coverage Determination L33718. |
| CP716 | Claims for A9279 (Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified) are denied as statutorily non-covered. Refer to Local Coverage Determination L33718 & Policy Article A52467. |

| Reason Code | E0470 |
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| CP800 | The medical record documentation does not support that an E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting. Refer to Local Coverage Determination L33718. |
| CP801 | The medical record documentation does not support lower pressure settings of the E0601 were tried but failed to adequately control symptoms of obstructive sleep apnea (OSA) or improve sleep quality or reduce the apnea-hypopnea index (AHI)/respiratory disturbance index (RDI) to acceptable levels. Refer to Policy Article A52467. |
| CP802 | The medical record documentation does not support that a new in-person clinical evaluation occurred after an E0601 was used for 3 or more months and the beneficiary was switched to an E0470. Refer to Local Coverage Determination L33718. |

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| Reason Code | ADMINISTRATIVE/OTHER <i>(For Transmission via esMD)</i> |
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| GEX04 | Other |
| GEX05 | The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable. |
| GEX06 | The documentation submitted is incomplete |
| GEX07 | This submission is an unsolicited response |
| GEX08 | The documentation submitted cannot be matched to a case/claim |
| GEX09 | This is a duplicate of a previously submitted transaction |
| GEX10 | The date(s) of service on the cover sheet received is missing or invalid. |
| GEX11 | The NPI on the cover sheet received is missing or invalid. |
| GEX12 | The state where services were provided is missing or invalid on the cover sheet received. |
| GEX13 | The Medicare ID on the cover sheet received is missing or invalid. |
| GEX14 | The billed amount on the cover sheet received is missing or invalid. |
| GEX15 | The contact phone number on the cover sheet received is missing or invalid. |
| GEX16 | The Beneficiary name on the cover sheet received is missing or invalid |
| GEX17 | The Claim number on the cover sheet received is missing or invalid |
| GEX18 | The ACN on the coversheet received is missing or invalid |
| GEX19 (Effective 10/01/2021) | Provider is exempted from submitting this PA request |