Reason Code	CRITERION A
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
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.
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 calculate the AHI or RDI Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718.

Reason Code	CRITERION C
CP200	***There is no documentation to support the provider of the PAP 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
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)
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 (RUL). Refer to National Coverage Determination 240.4 & Local Coverage Determination L33718.

Reason Code	BENE ENTERING MEDICARE
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
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.
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.

Reason Code	ACCESSORIES
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.
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**
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.

Reason Code	**ADMINISTRATIVE/OTHER** *(For Transmission via esMD)*
GEX04	Other
GEX05	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
GEX06	***The documentation is incomplete***
GEX07	This submission is an unsolicited response

GEX08	***The documentation cannot be matched to a case/claim***
GEX09	***This is a duplicate of a previous 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