MEDICAL POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Positive Airway Pressure Devices for Pulmonary Disorders Continued Rental-MP-MM-1323	11/01/2025 Kentucky inactive as of 01/01/2026
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

Table of Contents

A. Subject

Positive Airway Pressure Devices for Pulmonary Disorders Continued Rental

B. Background

Positive airway pressure (PAP) devices utilize a machine with a mask or other apparatus that fits over the nose and/or mouth to provide positive pressure, keeping airways open. Continuous positive airway pressure, or CPAP, is used to treat sleep-related breathing disorders, including sleep apnea. It also may be used to treat preterm infants with underdeveloped lungs. Bi-level or two-level positive airway pressure, or BiPAP, is used to treat lung disorders, such as chronic obstructive pulmonary disease (COPD). While CPAP delivers a single pressure, BiPAP delivers positive pressure both on inhalation and exhalation. PAP devices can provide better sleep quality, reduce or eliminate snoring, and lessen daytime sleepiness. PAP devices should always be used according to the physician's order, as well as every time during sleep at home, while traveling, and during naps in order to produce the most effective outcome.

C. Definitions

- **Adherence** – Use of the PAP device as prescribed by the ordering physician, defined as utilization for 4 or more hours per night for 70% of the nights during the most recent consecutive 30-day period during the first initial usage.
- **Bi-Level Positive Airway Pressure (BiPAP) Device** – A device that uses mild bi-level or 2 levels of air pressure to keep airways open.
- **Continuous Positive Airway Pressure (CPAP) Device** – A device that uses mild continuous air pressure to keep airways open.
- **Positive Airway Pressure (PAP) Device** – A device that uses air pressure to keep airways open, including both continuous positive airway pressure (CPAP) devices and bi-level positive airway pressure (BiPAP) devices.

D. Policy

I. PAP devices addressed in this policy include the following:
   A. E0601 – CPAP, continuous pressure capability, used with noninvasive nasal or face mask.
   B. E0470 – BiPAP, Bi-level pressure capability, without backup rate feature, used with noninvasive nasal or face mask.
   C. E0471 – BiPAP, Bi-level pressure capability, with backup rate feature, used with noninvasive nasal or face mask.
   D. E0472 – BiPAP, Bi-level pressure capability, with backup rate feature, used with invasive tracheostomy tube.

II. CareSource uses MCG Health clinical criteria to determine medical necessity for PAP devices, CPAP (E0601) and BiPAP (E0470):
   A. During the first 3 months rental, CareSource considers the device medically necessary when the MCG Health clinical criteria are met.
   B. For months 4-13 rental, CareSource considers the device medically necessary when documentation confirming adherence (see above definition) is submitted.

III. PAP devices BiPAP (E0471) and BiPAP (E0472) CareSource uses MCG Health clinical criteria to determine medical necessity.
   A. During the first 6 months rental, CareSource considers the device medically necessary when the MCG Health clinical criteria are met.
   B. For months 7-12 rental, CareSource considers the device medically necessary when documentation confirming adherence (see above definition) is submitted.
   C. Documentation confirming adherence must be submitted annually with the prior authorization request. CareSource considers the device medically necessary when **BOTH** the following are met:
      1. The MCG Health clinical criteria are met.
      2. Documentation confirming adherence (see above definition) is submitted.

E. State-Specific Information
NA

F. Conditions of Coverage
NA

G. Related Policies/Rules
Noninvasive Home Mechanical Ventilation

H. Review/Revision History

	DATE	ACTION
Date Issued	05/25/2022	New policy
Date Revised	06/07/2023 05/22/2024 08/28/2024 08/13/2025	Annual review. Updated references. Approved at Committee. Annual review. Removed supply chain disclaimer. Updated references. Approved at Committee. Annual review. Updated title. Revised D. II. and III. Updated references. Approved at Committee. Annual review. Updated references. Approved at Committee.
Date Effective	11/01/2025	
Date Archived		

I. References
1. Bi-level Positive Airway Pressure (BPAP) Device: ACG A-0994. MCG Health. 29th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
2. Continuous Positive Airway Pressure (CPAP) Device: ACG A-0431. MCG Health. 29th ed. Updated March 14, 2024. Accessed August 1, 2025. www.careweb.careguidelines.com
3. CPAP. National Heart, Lung, and Blood Institute. Updated March 24, 2022. Accessed August 1, 2025. www.nhlbi.nih.gov
4. *LCD Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)*. Centers for Medicare and Medicaid. Updated January 1, 2024. Accessed August 1, 2025. www.cms.gov

5. Patil SP, Ayappa IA, Caples SM, et al. Treatment of adult obstructive sleep apnea with positive airway pressure: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2019;15(02):335-343. doi:10.5664/jcsm.7640