MEDICAL POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Positive Airway Pressure Devices for Pulmonary Disorders Continued Rental-AR PASSE-MM-1586	09/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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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 recommends, for E0601, using RR modifier and NU modifier or no modifiers to promote timely claims processing.

III. CareSource recommends, for E0470, E0471 or E0472, using RR modifier plus 1 of the following to promote timely claims processing
   A. Use modifier EP for beneficiaries under the age of 21.

B. Use modifier NU for beneficiaries aged 21 and over.

Note: 1 unit = 1 day rental with RR modifier

IV. CareSource uses MCG Health clinical criteria to determine medical necessity for PAP devices, CPAP (E0601), and BiPAP (E0470):
A. During the first 90 days rental (3 months), CareSource considers the device medically necessary when the MCG Health clinical criteria are met.
B. For rental months 4-15, CareSource considers the device medically necessary when documentation confirming adherence (see above definition) is submitted.

Note: CPAP (E0601) and BiPAP (E0470) are 15 months rent to purchase.

V. 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 medical necessity review 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.

VI. Supplies
CareSource requires
A. a medical necessity review
B. supplies and accessories for PAP devices be submitted using

CODE	DESCRIPTION
A9999	Unlisted Durable Medical Equipment. The manufacturer's invoice must be attached to the claim form. Misc. DME supply or accessory, not otherwise specified

C. no modifier when submitting A9999

E. Conditions of Coverage
NA

F. Related Policies/Rules
Noninvasive Home Mechanical Ventilation

G. Review/Revision History

	DATE	ACTION
Date Issued	08/28/2024	New policy. Approved at Committee.
Date Revised	07/02/2025	Periodic review. Added D. VI. Approved at Committee.

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

	06/17/2025	Periodic review. Updated references. Approved at Committee.
Date Effective	09/01/2026	
Date Archived		

H. References

1. Bi-level Positive Airway Pressure (BPAP) Device: ACG A-0994. MCG Health. 30th ed. Updated January 25, 2026. Accessed June 04, 2026. www.careweb.careguidelines.com
2. Continuous Positive Airway Pressure (CPAP) Device: ACG A-0431. MCG Health. 30th ed. Updated January 25, 2026. Accessed June 04, 2026. www.careweb.careguidelines.com
3. CPAP. National Heart, Lung, and Blood Institute. Updated March 24, 2022. Accessed June 04, 2026. 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 June 04, 2026. 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
6. *Prosthetics/Durable Medical Equipment (DME) Procedure Code Table*. Division of Medical Services. Arkansas Medicaid. Accessed June 04, 2026. www.humanservices.arkansas.gov
7. *Prosthetics (Includes DME And Orthotics) Provider Manual, Section II*. Arkansas Dept of Health and Human Services. Accessed June 04, 2026. www.humanservices.arkansas.gov