MEDICAL POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Positive Airway Pressure Devices for Pulmonary Disorders Continued Rental-TrueCare-MM-1836	07/01/2025-05/31/2026
Policy Type	
MEDICAL	

Medical Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Medical Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) 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, then the plan contract 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.

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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 non-continuous, bilevel airway management device that cycles between the inspiratory and expiratory pressure levels in response to the patient's respiratory effort.
- **Continuous Positive Airway Pressure (CPAP) Device** – A non-invasive provision of air pressure through nasal administration and a flow generator system to prevent collapse of the oropharyngeal walls during sleep.
- **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. TrueCare uses MCG Health clinical criteria to determine medical necessity for PAP devices, CPAP (E0601) and BiPAP (E0470):
   A. During the first 3 months rental, TrueCare considers the device medically necessary when the MCG Health clinical criteria are met.

B. For months 4-10 rental, TrueCare considers the device medically necessary when documentation confirming adherence (see above definition) is submitted.

III. PAP devices BiPAP (E0471) and BiPAP (E0472) TrueCare uses MCG Health to determine medical necessity.
   A. During the first 6 months rental, TrueCare considers the device medically necessary when the MCG Health clinical criteria are met.
   B. For months 7-12 rental, TrueCare 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. TrueCare 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. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	06/25/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived	05/31/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References
1. Administrative Code Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies. Accessed June 13, 2025. www.medicaid.ms.gov
2. Bi-level Positive Airway Pressure (BPAP) Device: ACG A-0994. MCG Health. 28th ed. Accessed June 13, 2025. www.careweb.careguidelines.com
3. Continuous Positive Airway Pressure (CPAP) Device: ACG A-0431. MCG Health. 28th ed. Accessed June 13, 2025. www.careweb.careguidelines.com
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 13, 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