MEDICAL POLICY

Medical Policy Title	**Continuous Positive Airway Pressure (CPAP) and Auto-Adjusting Positive Airway Pressure (APAP) Devices**
Policy Number	**1.01.06**
Current Effective Date	**January 1, 2027**
Next Review Date	**June 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

POLICY STATEMENT(S)

Initial 90-day Trial

Continuous Positive Airway Pressure and Auto-Adjusting Devices

I. Continuous positive airway pressure (CPAP) and auto-adjusting positive airway pressure (APAP) devices are considered **medically appropriate** for **ANY** of the following indications:

A. Adults with obstructive sleep apnea (OSA) who meet **ONE** of the following indications:

1. Polysomnography (PSG) or home sleep testing (HST) results documenting an apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) of >5 (five), and <15 respiratory events per hour and **ONE** of the following associated symptoms:

a. Symptoms of OSA (e.g., excessive daytime sleepiness, impaired cognition, insomnia); **or**

b. Documented cardiovascular diseases, including hypertension, ischemic heart disease, or history of stroke; **or**

2. PSG or HST results document an AHI or RDI of ≥15 respiratory events per hour.

B. Children <18 years with OSA who meet **ONE** of the following indications: (Please note that a 90-day continuation review is not required for pediatric members.)

1. Failure of adenotonsillectomy to relieve OSA symptoms;

2. A contraindication to surgical intervention; **or**

3. For whom a nonsurgical approach is strongly preferred; **and**

4. **Either** of the following criteria:

a. PSG results documenting an AHI or RDI of ≥5 and exhibits OSA symptoms; **or**

b. PSG results demonstrated an AHI or RDI within normal ranges and the individual exhibits OSA symptoms (e.g., excessive daytime sleepiness, impaired cognition, insomnia) **and ONE** of the following:

i. The child exhibits episodes of hypercarbia based on end-tidal CO_2 measurements >53 mm Hg; **or**

ii. The end-tidal CO_2 is >50 mmHg for 10 to 24% of the sleep time.

Continuation of Use (Past 90-day Trial)

II. Continuation of coverage after the 90-day trial is **medically appropriate** when **BOTH** of the following have been demonstrated.

A. Improved AHI and symptom resolution during trial; **and**

B. Compliance has been demonstrated (e.g., defined by using the device for 70% of the nights, for four (4) or more hours per 24-hour period, during a consecutive 30-day period).

III. CPAP is **not medically necessary** for the treatment of snoring without accompanying OSA.

Durable Medical Equipment (DME) Repair

IV. Repair of a medically necessary CPAP or components not under warranty will be considered **medically appropriate** when the following criteria are met:

A. Physician documentation includes **ALL** the following:

1. Date of DME initiation;
2. Manufacturer warranty information, if applicable;
3. Attestation that the patient has been compliant with the use of the DME and will continue to benefit from the use of the DME;

B. The DME is no longer functioning adequately; and **BOTH** of the following criteria are met:

1. Inadequate function interferes with activities of daily living; and
2. Repair is expected to make the equipment fully functional (as defined by manufacturer).

V. Repair of equipment damaged due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

DME Replacement

VI. Replacement of a medically necessary CPAP or components not under warranty will be considered **medically appropriate** when **ALL** of the following criteria are met:

A. For positive pressure devices proof of compliance needs to be documented (refer to continuation of coverage after 90-day trial).

B. **Either** of the Following:

1. The DME is no longer functioning adequately and has been determined to be non-repairable, or the cost of the repair is in excess of the replacement cost;
2. There is documentation that a change in the patient's condition makes the present unit

non-functional and improvement is expected with a replacement unit.

VII. The replacement of a properly functioning CPAP, its components or accessories is considered **not medically necessary**. This includes, but is not limited to, replacement desired due to advanced technology or to make the DME more aesthetically pleasing;

VIII. The replacement of equipment damaged or lost due to patient neglect, theft, abuse, or when another available coverage source is an option (e.g., homeowners, rental, auto, liability insurance, etc.) is **ineligible for coverage**.

IX. Accessories or components for CPAP that are considered not medically necessary or investigational by peer-reviewed literature will also be considered as **not medically necessary or investigational** by the Health Plan.

RELATED POLICIES

Corporate Medical Policy

1.01.57 Home Non-Invasive Positive Pressure Ventilation (NIPPV) devices for Respiratory Insufficiency and Failure

2.01.28 Sleep Studies

7.01.41 Surgical Management of Sleep Disorders

11.01.03 Experimental or Investigational Services

POLICY GUIDELINE(S)

I. Individuals who do not meet the criteria for continuation of coverage during the initial 90 day trial are eligible to re-qualify for a CPAP device, but must have a clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to CPAP therapy (e.g., documentation of failure of symptoms to resolve or improper fit of device, and re-education of the individuals regarding proper use of the equipment or re-fitting of masks).

II. CPAP with expiratory relief or APAP are options for patients who cannot tolerate the high constant air pressure associated with CPAP but wish to continue treatment for OSA.

III. Supplemental oxygen or humidification can be added to positive pressure devices to increase oxygen saturation and decrease vasomotor rhinitis.

IV. Coverage is allowed for a one-month rental when the CPAP device is malfunctioning and out of warranty, (and not associated with a manufacturer recall) while the device is being repaired.

V. The monitoring feature/device, stand-alone or integrated, any type, including all accessories, components, and electronics, not otherwise classified (HCPCS: A9279) is considered inclusive to the positive airway pressure device.

VI. Devices used to clean or sanitize CPAP devices are considered a convenience item and are **ineligible for coverage** (e.g., SoClean, SoClean 2 Go).

DESCRIPTION

Sleep Apnea

Sleep apnea is a common sleep disorder characterized by repeated interruptions in breathing during sleep. These interruptions called apnea can occur hundreds of times per night which can lead to fragmented sleep and decreased oxygen levels resulting in daytime fatigue, cardiovascular problems, and other health issues.

Obstructive Sleep Apnea (OSA)

Obstructive sleep apnea (OSA) is a sleep-related breathing disorder caused by upper-airway obstruction, most often from relaxed throat muscles during sleep. In adults, OSA involves recurrent episodes of complete or partial upper airway blockage lasting more than 10 seconds and is commonly linked to obesity, male sex, aging, and anatomical factors. Symptoms include loud snoring, witnessed apneas, gasping, excessive daytime sleepiness, and hypertension, and diagnosis requires polysomnography or home sleep testing with evidence of clinical impairment. Untreated adult OSA increases the risk of hypertension, heart failure, atrial fibrillation, other arrhythmias, and nonalcoholic fatty liver disease.

Pediatric OSA, typically caused by enlarged tonsils and adenoids, is defined by prolonged partial obstruction or intermittent complete obstruction lasting at least two respiratory cycles and may present with snoring, breathing pauses, restless sleep, behavioral issues, or poor growth. If left untreated, children may experience growth abnormalities, neurologic problems, or cor pulmonale. Polysomnography (PSG) is the preferred diagnostic tool, although normative AHI/RDI values for children are not well established. Adenotonsillectomy is first-line therapy for pediatric OSA, while persistent cases or those with contraindications may require CPAP, observation, medications, or additional airway surgery. Obstructive hypoventilation (OH), a related condition in children, may present with normal AHI but episodes of hypercarbia indicated by elevated end-tidal CO_2.

Central Apneas

Central sleep apnea is defined as the cessation of airflow through the nose and mouth for at least 10 seconds with no respiratory effort noted. The cessation in breathing can be caused by problems involving brain mechanisms, or an obstructive component. Approximately 4% of individuals undergoing PSG in a sleep laboratory are diagnosed with central sleep apnea, making this an uncommon condition.

Mixed Apneas

Mixed sleep apnea is a combination of obstructive and central sleep apnea. Not only does the patient have an obstruction in the airway, but the patient may have a neurological dysfunction or cardiopulmonary as well that contributes to the central apnea component.

Continuous Positive Airway Pressure (CPAP)

CPAP is the gold standard treatment option for adults with documented OSA. The symptoms associated with OSA, such as excessive daytime sleepiness, impaired cognition, and mood disorders

are reduced or eliminated with the consistent use of CPAP. CPAP is not indicated in individuals with simple snoring that is not associated with pauses in respirations. Treatment recommendations for OSA are based primarily on the RDI or the AHI, the severity of the presenting symptoms, and the existence and severity of co-morbid conditions.

CPAP provides constant pressure throughout the respiratory cycle by raising the intraluminal upper airway pressure above the positive critical transmural pressure of the pharynx or hypopharynx. The pressure is delivered by a flow generator through either nasal mask or modified nasal prongs to keep the upper airway patent resulting in adequate ventilation and arterial oxygenation. The pressure used is determined individually, with a range of 3 to 20 cm. water.

Auto- or Self-Titrating Positive Airway Pressure (APAP)

Auto- or self-titrating positive airway pressure, or APAP, systems utilize an algorithm that uses a pressure transducer and microprocessor to monitor the airway for vibration patterns and then makes air pressure adjustments based on the incidence of apnea or absence of vibration. APAP devices are also referred to as demand positive airway pressure devices (DPAP).

CPAP with expiratory relief (e.g., C- Flex technology Respironics, Inc., Murrysville, PA) is designed to provide pressure relief during expiration, while maintaining optimal pneumatic splinting for effective therapy. CPAP with expiratory relief technology monitors the patient's airflow during expiration and reduces expiratory pressure proportional to expiratory flow. CPAP with C-Flex technology can increase compliance in those patients who find it difficult or uncomfortable to breathe out against the continuous positive pressure. This technology can be applied to CPAP, BPAP and APAP devices.

Most PAP machines now contain a data card that can record and transmit daily use rates of the device. In addition, most PAP machines can also be equipped with a modem (either wired or wireless) that is capable of transmitting data daily to a manufacturer-owned database. The ability to detect disturbances in a variety of measures, including air flow, amount of time used, and mask leak, is also included in most commercially available PAP machines.

SUPPORTIVE LITERATURE

Sanchez-de la-Torre et al (2023) conducted a systematic review and meta-analysis of individual participant data (IPD) from three randomized controlled trials (RCT, Sleep Apnea Cardiovascular Endpoints (SAVE), Impact of Sleep Apnea Syndrome in Acute Coronary Syndrome (ISAACC) and Randomized Intervention with CPAP in Coronary Artery Disease and Sleep Apnea (RICCADSAO) to assess whether adherence to CPAP therapy reduces the risk of major adverse cardiac and cerebrovascular events (MACCEs) in individuals with OSA and established cardiovascular disease. The study included 4186 adults with cardiovascular disease and OSA. The primary outcome was the first MACCEs. Statistical analysis included one stage and two stage IPD meta-analysis as well as on treatment analysis using marginal structural models to assess the effects of CPAP adherence. A total of 691 MACCEs (16.5%) were observed, the CPAP group had 349 and the no CPAP group 342. The main outcome intention- to-treat analysis did not show a significant difference in MACCEs between the CPAP and the no CPAP group. The on-treatment analysis revealed good adherence to CPAP (≥4 hours per day) was associated with a reduced risk of MAACEs reoccurrence. Adherence to CPAP was

associated with reduced MACCE recurrent risks suggesting that treatment adherence is a key factor in secondary cardiovascular prevention in individuals with OSA.

Patil et al (2019) conducted a systematic review and meta-analysis of 184 studies to evaluate the effectiveness of PAP therapy for adults with OSA. CPAP significantly reduced AHI by 23 events/hour versus no treatment—an 86% reduction from 32.7 to 4.1 events/hour. CPAP also improved daytime sleepiness by 2.4 points in symptomatic patients and showed clinically meaningful benefits for sleep-related quality of life, blood pressure, and motor vehicle crash risk. Observational evidence suggested reductions in cardiovascular events and mortality, though RCTs did not confirm these outcomes. No major differences were found among CPAP, APAP, and BiPAP for individual clinical outcomes, supporting CPAP as first-line therapy unless not tolerated. Home-based versus in-lab APAP initiation showed comparable results. Education, behavioral interventions, and telemonitoring improved adherence. Nasal masks enhanced adherence and reduced AHI more effectively than oronasal masks. Humidification reduced side effects without improving adherence or outcomes. Overall, CPAP reliably reduces OSA severity, improves sleepiness, and lowers blood pressure, particularly in symptomatic or hypertensive adults. Benefits for asymptomatic individuals and long-term cardiovascular outcomes remain uncertain.

Wang et al (2019) conducted a systematic review to assess the effectiveness of home noninvasive NIPPV (home mechanical ventilation (HMV), BiPAP, or CPAP devices) in adults with chronic respiratory failure. 68 studies evaluating 53,733 patients were included. In patients with COPD, home BiPAP (compared to no device) was associated with lower mortality, decreased need for intubations and hospital admissions, but no change in quality of life. In patients with COPD, HMV (compared individually with BiPAP, CPAP, or no device) was associated with fewer hospital admissions. In patients with thoracic restrictive diseases, HMV (compared to no device) was associated with lower mortality. In patients with neuromuscular diseases, home BiPAP (compared to no device) was associated with lower mortality and better quality of life. In patients with obesity hypoventilation syndrome, home HMV/BiPAP (compared to no device) was associated with lower mortality. Current evidence was not available to assess the comparative effectiveness of many device capabilities on patient outcomes. Criteria to initiate home NIPPV and home respiratory services varied and were not validated in comparative studies.

PROFESSIONAL GUIDELINE(S)

The 2021 National Institute for Health and Care Excellence (NICE) Clinical Guidelines for Diagnosis and Management of Obstructive Sleep Apnea/Hypopnea Syndrome (OASAHS), Obesity Hypoventilation Syndrome (OHS) and Chronic Obstructive Pulmonary Disease with OSAHS (COPD-OSAHS overlap syndrome) in people over 16 years of age.

- Offering fixed-level CPAP in those with mild OSA when symptoms affect quality of life (QOL) and usual daytime activities if lifestyle changes alone have been unsuccessful or are considered inappropriate.
- APAP as an alternative to fixed-level CPAP in those unable to tolerate CPAP.

- In individuals who cannot tolerate or refuse CPAP, they recommend offering a customized mandibular advancement device.
- In individuals with moderate to severe OSA, CPAP is recommended as a treatment option, with APAP offered as an alternative in those unable to tolerate CPAP.
- A customized mandibular advancement device may be used if an individual refuses PAP or is unable to tolerate PAP.
- A positional modifier may be considered for those with mild to moderate positional OSA if other treatments are unsuitable or not tolerated, but this should not be a first-line treatment option.
- The European Respiratory Society (ERS) and the American Thoracic Society (ATS) Clinical Recommendation for non-invasive ventilation (NIV) in Adults with Acute Respiratory Failure (ARF) (Rochwerg 2017). Bilevel NIV for individuals with ARF leading to acute or acute-on-chronic respiratory acidosis (pH <7.35) due to COPD exacerbation. (Strong recommendation, high certainty of evidence.)
- Either bilevel NIV or CPAP for individuals with ARF due to cardiogenic pulmonary oedema. (Strong recommendation, moderate certainty of evidence.
- Early NIV for immunocompromised individuals ARF. (Conditional recommendation, moderate certainty of evidence.)
- Due to the uncertainty of evidence ERS/ATS is unable to offer a recommendation on the use of NIV for de novo ARF.
- NIV for individuals with post-operative ARF. (Conditional recommendation, moderate certainty of evidence.)
- NIV to dyspneic individuals for palliation in the setting of terminal cancer or other terminal conditions. (Conditional recommendation, moderate certainty of evidence.)
- NIV should not be used in the treatment of patients with established post-extubation respiratory failure. (Conditional recommendation, low certainty of evidence.

The American Academy of Pediatrics Clinical Guidelines for the Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome (OSAS) (2012).

- All children/adolescents should be screened for snoring.
- Polysomnography should be performed in children/adolescents with snoring and symptoms/signs of OSAS; if polysomnography is not available, then alternative diagnostic tests or referral to a specialist for more extensive evaluation may be considered.
- Adenotonsillectomy is recommended as the first-line treatment of patients with adenotonsillar hypertrophy.
    - High-risk patients should be monitored as inpatients postoperatively.
    - Patients should be reevaluated postoperatively to determine whether further treatment is

required. Objective testing should be performed in patients who are high risk or have persistent symptoms/signs of OSAS after therapy.

- Continuous positive airway pressure is recommended as treatment if adenotonsillectomy is not performed or if OSAS persists postoperatively.

- Weight loss is recommended in addition to other therapy in patients who are overweight or obese.
- Intranasal corticosteroids are an option for children with mild OSAS in whom adenotonsillectomy is contraindicated or for mild postoperative OSAS.

American Academy of Sleep Medicine (ASSM 2008) Clinical Guidelines for the Manual Titration of Positive Airway Pressure in Patient with OSA.

- Pre-Titration Preparation: All candidates should receive PAP education, hands-on demonstration, careful mask fitting, and acclimatization. (Standard)
- Transition to BiPAP: If a patient is uncomfortable or intolerant of high CPAP pressures, or obstructive respiratory events continue at 15 cm H2O, switch the patient to BiPAP. (Consensus)
- Repeat Titration Study: Consider repeating a titration if the initial titration was not optimal/good and, for split-night studies, fails to meet AASM criteria. (Consensus)

REGULATORY STATUS

The United States Food and Drug Administration (FDA) regulates PAP devices as medical devices. All PAP devices including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2026 Feb 13]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most serious type of recalls on our website by the date that the FDA posts the information on our website. Available from: Medical Device Recalls | FDA [accessed 2026 Feb 13]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

CPT Codes

Code	Description
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management

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HCPCS Codes

Code	Description
A7027-A7039	Accessories/supplies, code range for positive pressure airway devices (code range)
A7044-A7046	Accessories/supplies, code range for positive pressure airway devices (code range)
A9279	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified
E0561	Humidifier, nonheated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device
E0601	Continuous airway pressure (CPAP) device

ICD10 Codes

Code	Description
E66.2	Morbid (severe) obesity with alveolar hypoventilation
G47.00	Insomnia, unspecified
G47.10	Hypersomnia, unspecified
G47.20	Circadian rhythm sleep disorder, unspecified type
G47.8	Other sleep disorders
G47.9	Sleep disorder, unspecified
I50.9	Heart failure, unspecified
J39.8	Other specified diseases of upper respiratory tract
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified

Code	Description
J95.2	Acute pulmonary insufficiency following nonthoracic surgery
J96.00-J96.02	Acute respiratory failure (code range)
J96.10-J96.12	Chronic respiratory failure (code range)
J96.20-J96.22	Acute and chronic respiratory failure (code range)
J96.90-J96.92	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia (code range)
J98.4	Other disorders of lung
J98.8	Other specified respiratory disorders

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SEARCH TERMS

Not Applicable

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Respiratory Assist Devices (LCD L33800) [accessed 2026 Feb 13]

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (LCD L33718)

[accessed 2026 Feb 13]

Durable Medical Equipment Reference List (NCD 280.1) [accessed 2026 Feb 13]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

POLICY HISTORY/REVISION	
Committee Approval Dates	
01/01/27	
Date	**Summary of Changes**
01/01/27	• Original effective date