Medical Coverage Policy
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Positive airway pressure devices

Background

Positive airway pressure respiration is a type of ventilation in which air is pushed under pressure through the nose and into the lungs. This prevents collapse of the respiratory tract and allows unobstructed breathing during sleep.

Continuous positive airway pressure (CPAP) devices deliver air under a fixed level of pressure throughout inspiration and expiration. CPAP titration is required to identify the type of interface (e.g., nasal mask, mouth-nasal cradle mask, and so on) and the amount of pressure that is optimal for the patient. Titration can be done at home or in a facility.

Bilevel positive airway pressure (BiPAP) devices deliver air at a higher pressure for inhalation and a lower pressure for exhalation. These can be used in individuals who cannot tolerate CPAP or in patients with obesity hypoventilation syndrome.

Auto-titrating continuous positive airway pressure (APAP) devices titrate effective airway pressure throughout the night automatically, based on physiologic signals. These devices can reduce air pressure when spells of apnea disappear and increase pressure when they return. APAP can be used to determine an optimal level for CPAP machines for long term treatment with conventional CPAP devices.

Policy Statement

Disclaimer: This policy is applicable to TRICARE Prime & Select beneficiaries, and may not apply to Active Duty Service Members (ADSM) under SHCP or TPR in accordance with TOM Chapter 17, Section 3. Please review TOM Chapter 17, Section 3, Paragraph 2.0 onwards, regarding SHCP coverage and any TRICARE specific exclusions included in this coverage policy to accurately determine the benefit for ADSMs

CPAP devices may be covered for the following indications:

I. Adult with diagnosis of obstructive sleep apnea (OSA) and one or more of the following:
    a. Mild OSA (apnea-hypopnea index between 5-15) and one or more of the following:
        i. Documented cardiovascular disease (e.g. hypertension, heart failure)
        ii. Excessive daytime sleepiness
        iii. Impaired cognition
        iv. Mood disorder
        v. Observed apneic or choking episodes
        vi. Night sweats
        vii. Snoring
        viii. Headaches on awakening
        ix. Heartburn and reflux
        x. Documented fibromyalgia-like symptoms

b. Moderate or severe OSA (AHI greater than or equal to 15)
c. Upper airway resistance syndrome and unexplained excessive daytime sleepiness

II. Child with diagnosis of OSA and one or more of the following:
   a. Mild OSA (AHI between 1 and 5) and one or more of the following:
      i. Achondroplasia
      ii. Behavioral problems
      iii. Cardiovascular disease
      iv. Chiari malformation
      v. Craniofacial abnormalities
      vi. Down syndrome
      vii. Excessive daytime sleepiness
      viii. Impaired cognition
      ix. Inattention or hyperactivity
      x. Mucopolysaccharoidoses
      xi. Neuromuscular disorders
      xii. Prader-Willi syndrome
   b. Moderate or severe OSA (AHI greater than 5)
   c. Persistent OSA after adenotonsillectomy
III. Central sleep apnea syndrome due to congestive heart failure in adult
IV. Obesity hypoventilation syndrome, as indicated by one or more of the following:
   a. BMI greater than 30
   b. Daytime hypercapnia with $PaCO_2$ greater than 45 mm Hg without other etiology

Limitations of Coverage

1. Continuation of CPAP after initial authorization will be based on compliance and effectiveness

BiPAP devices may be covered for the following indications:

I. Adult meets OSA criteria for CPAP listed above and CPAP unsuccessful or not appropriate as demonstrated by one of the following:
   a. Titration study demonstrated OSA despite CPAP 15 cm H_2O that is responsive to BiPAP
   b. Intolerance of CPAP pressures, i.e. difficulty exhaling against fixed airway pressure
   c. Comorbid sleep-related hypoventilation (ie, arterial, end-tidal, or transcutaneous PCO_2 greater than 55 mm Hg (7.3 kPa) for 10 minutes or longer, or increase in arterial, end-tidal, or transcutaneous PCO_2 of 10 mm Hg (1.3 kPa) or greater above awake supine value resulting in PCO_2 greater than 50 mm Hg (6.7 kPa) for 10 minutes or longer) in patient with obstructive sleep apnea

II. Child meets OSA criteria for CPAP listed above and CPAP unsuccessful or not appropriate as indicted by one of the following:
    a. Comorbid sleep-related hypoventilation (ie, sleeping arterial, end-tidal, or transcutaneous PCO_2 of greater than 50 mm Hg (6.7 kPa) for greater than 25% of total sleep time, or peak sleep end-tidal PCO_2 of 55 mm Hg (7.3 kPa) or greater) in patient with obstructive sleep apnea
    b. Intolerance of CPAP pressures, i.e. difficulty exhaling against fixed airway pressure
    c. Ongoing obstructive sleep apnea despite CPAP 15 cm H_2O (1471 Pa) during titration study that responds to BiPAP
III. Diagnosis of Central sleep apnea (idiopathic) on diagnostic polysomnography and titration study demonstrates improvement in AHI
IV. Chronic obstructive pulmonary disease (COPD) with one of the following:
    a. Chronic hypercapnia with $PaCO_2$ of 50 mm Hg (6.7 kPa) to less than 52 mm Hg (6.9 kPa) and one or more of the following:
        i. Arterial oxygen saturation less than or equal to 88% for five consecutive minutes during nocturnal oximetry while on at least two liters of oxygen per minute
        ii. Invasive or noninvasive ventilation for acute exacerbation required during two or more hospitalizations per year
    b. Chronic hypercapnia with with $PaCO_2$ of 52 mm Hg (6.9 kPa) or greater
    c. Palliative care in patient with end-stage disease and advance directive stating no desire for intubation
V. End stage lung disease with hypercapnic respiratory failure
VI. Obesity hypoventilation syndrome and one of the following:
    a. Increase in $PaCO_2$ during sleep by more than 10 mm Hg above value while awake
    b. Significant oxygen desaturation (less than 90%) not explained by obstructive apneas or hypopneas
VII. Repiratory insufficiency and BiPAP with backup rate needed, as indicated by all of the following:
    a. Chest wall deformity or neuromuscular disease
    b. Signs of respiratory insufficiency, as indicated by one of the following:
        i. Arterial oxygen saturation less than 88% for 5 consecutive minutes during nocturnal oximetry
        ii. Daytime PCO_2 (ie, arterial or capillary) greater than 45 mm Hg (6.0 kPa)
        iii. Forced vital capacity less than 50% of predicted
        iv. Maximum inspiratory pressure less than or equal to 60 cm H_2O (5884 Pa)
    c. No anatomic abnormality that precludes mask fitting
    d. No impaired cough or inability of mechanically assisted cough to clear secretions
    e. Patient able to protect airway

TRICARE Policy Manual Chapter 8, section 2.1

3.10 Replacements. Benefits are allowed for replacement of beneficiary-owned DE with documentation that the DE is lost or stolen and not otherwise covered by another insurance (such as a homeowner's policy). Replacement of beneficiary-owned DE is also allowed when the item is not functional due to normal wear, accidental damage, a change in the beneficiary's condition, or the device has been declared adulterated by the FDA. (Exceptions exist for prosthetic devices; see Section 4.1 for more information.)

Note: Replacement is subject to review of documentation supporting why the current DE item is no longer usable/repairable and that the replacement cost is less than the repair cost.

Note: Replacement equipment is allowed only upon a new order or prescription by a TRICARE authorized individual professional provider with an explanation of the medical need.

3.10.1 When a rented item of DE is lost or stolen, the supplier shall use modifier RA to notify the TRICARE contractor that the item has been lost or stolen, and a replacement item is being provided. Payment for the original rented item of DE that was lost or stolen is the contractual responsibility of the supplier.

3.10.2 The TRICARE program will not continue to pay rental fees on equipment that has been lost or stolen. Once the medically necessary DE has been replaced by the supplier and provided to the beneficiary, rental fees for the replacement item shall resume based upon the continuous use provision, if applicable.

3.11 An item of DE which otherwise meets the DE benefits requirement that is essential to provide a fail-safe in-home life-support system, or that replace in-like-kind an item of equipment that is not serviceable because of normal wear, accidental damage, a change in the beneficiary's condition, has been declared adulterated by the FDA, or is being, or has been recalled by the manufacturer, is not considered duplicate and, therefore is covered.

Note: For the purpose of this policy, "duplicate" means an item of equipment that meets the definition of DE and serves the same purpose as an item of DE previously cost-shared by the TRICARE program. For example, various models of a stationary oxygen concentrator with no significant differences are considered duplicates, whereas stationary and portable concentrators are not considered duplicates of each other because the latter is intended to provide a beneficiary with mobility outside the home. Another example is an electric wheelchair, which otherwise meets the definition of DE would not be duplicative of a manual wheelchair previously cost-shared by the TRICARE program in that the electric wheelchair provides independent mobility not provided by the manual wheelchair.

Coding Information

Code	Description
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0471	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask (intermittent assist device with continuous positive airway pressure device)
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g., tracheostomy tube (intermittent assist device with continuous positive airway pressure device)
E0601	Continuous positive airway pressure (CPAP) device

References

1. TRICARE Operations Manual Chapter 17, Section 3 TRICARE Manuals - Display Chap 17 Sect 3 (Change 44, Jul 8, 2025)
2. MCG Health. Continuous Positive Airway Pressure (CPAP) Device. ACG: A-0431 (AC). Ambulatory Care 29th edition. Last updated 01/25/2025
3. MCG Health. Bilevel Positive Airway Pressure Device (BiPAP). ACG: A-0994 (AC). Ambulatory Care 29th Edition. Last updated 01/25/2025

Revision History

July 2025: Updated references

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