Medical Policy

Bi-Level Positive Airway Pressure (BPAP) Devices

Table of Contents

- Policy: Commercial
- Policy: Medicare
- Authorization Information
- Coding Information
- Description
- Policy History
- Information Pertaining to All Policies
- References
- Endnotes

Policy Number: 527

BCBSA Reference Number: NA
NCD/LCD: Local Coverage Determination (LCD): Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)

Related Policies

- Actigraphy, #533
- Home Cardiorespiratory Monitoring, #224
- Management of Obstructive Sleep Apnea - OSA Oral Appliances, #529
- Management of Obstructive Sleep Apnea (OSA) using Auto-Titrating Positive Airway Pressure (APAP) and Continuous Positive Airway Pressure (CPAP) Devices, #526
- Polysomnography and Home Sleep Testing, #525
- Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome, #130
- Multiple Sleep Latency Testing - MSLT and Maintenance of Wakefulness Testing - MWT, #534

Policy¹

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Indications for Bi-Level Positive Airway Pressure Devices (BPAP)

Bi-Level Positive Airway Pressure (BPAP) Devices may be considered MEDICALLY NECESSARY for the following conditions:

**BPAP (without back-up rate feature)**
- Appropriate for patients with OSA who have failed CPAP/APAP or require supplemental ventilatory support due to a hypoventilation syndrome

**BPAP (with back-up rate feature)**
- Appropriate for patients with established CSA diagnosed by an in-lab sleep study when left ventricular ejection fraction (LVEF) is >45% and all of the following (a-c) apply:
  a. OSA has been excluded or treated
  b. Oxygen saturation level is 88% or less for at least five (5) continuous minutes while the patient breathes his/her usual FiO2 OR the patient demonstrates Cheyne Stokes respiration for five (5)
continuous minutes with oxygen saturation falling to 88% or less at least once during that 5 minute interval

c. A titration study (split-night or whole-night) has demonstrated significant improvement of sleep-related hypoventilation adjusted to the settings that will be prescribed for home use (while breathing the individual’s usual FiO2).

**BPAP (with or without back-up rate feature)**
- Appropriate in the management of patients with severe COPD demonstrating either of the following (a or b):
  a. PaCO2 measured by arterial blood gas drawn while the patient is awake and breathing his/her usual FiO2 is 45 mmHg or greater; **OR**
  b. Sleep oximetry demonstrates oxygen saturation of 88% or less for at least five continuous minutes while the patient breathes oxygen at 2L per minute or his/her usual FiO2 (whichever is higher).

**BPAP (with or without back-up rate feature)**
- Appropriate in the management of patients with certain restrictive thoracic disorders when both a and b below are true:
  a. The patient has an established diagnosis of a progressive neuromuscular disease, e.g., amyotrophic lateral sclerosis (ALS) **OR** a severe thoracic cage abnormality; **AND**
  b. One of the following statements is true:
    - PaCO2 measured by arterial blood gas drawn while the patient is awake and breathing his/her usual FiO2 is 45 mmHg or greater.
    - Sleep oximetry demonstrates oxygen saturation of 88% or less for at least five continuous minutes while the patient breathes his/her usual FiO2
    - Maximal inspiratory pressure is less than 60 cm H2O or forced vital capacity is less than 50% of predicted (applies to patients with progressive neuromuscular disease only).

**Ongoing treatment with BPAP:**
Ongoing treatment is indicated for patients who demonstrate compliance with therapy. Demonstration of compliance is required every 90 days for the first year of treatment and annually thereafter. Compliance is defined as:
1. Use of the BPAP device for greater than or equal to four (4) hours per night on 70% of nights during a consecutive thirty (30) day period within the preceding 90 days; **OR**
2. There is clinical evidence submitted by the treating provider that demonstrates continued clinical benefit from use of the positive airway pressure device.

**Medicare HMO BlueSM and Medicare PPO BlueSM Members**

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the link below.

[Local Coverage Determination (LCD): Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L33718)]

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

**Prior Authorization Information**
Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required for outpatient services.
Yes indicates that prior authorization is required.
No indicates that prior authorization is not required.
N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th><strong>Outpatient</strong></th>
<th>The requirements of BCBSMA Sleep Disorder Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific: please verify member eligibility and requirements through AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial Managed Care (HMO and POS)</strong></td>
<td>The requirements of BCBSMA Sleep Disorder Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific: please verify member eligibility and requirements through AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783.</td>
</tr>
<tr>
<td><strong>Commercial PPO and Indemnity</strong></td>
<td>The requirements of BCBSMA Sleep Disorder Management Program may require a precertification/prior authorization via AIM Specialty Health. These requirements are member-specific: please verify member eligibility and requirements through AIM Specialty Health at <a href="http://www.aimspecialtyhealth.com">www.aimspecialtyhealth.com</a> or call 1-866-745-1783.</td>
</tr>
<tr>
<td><strong>Medicare HMO BlueSM</strong></td>
<td>No</td>
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<tr>
<td><strong>Medicare PPO BlueSM</strong></td>
<td>No</td>
</tr>
</tbody>
</table>

**CPT Codes / HCPCS Codes / ICD Codes**
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**HCPCS Codes**

<table>
<thead>
<tr>
<th><strong>HCPCS codes:</strong></th>
<th><strong>Code Description</strong></th>
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</thead>
<tbody>
<tr>
<td>E0470</td>
<td>Respiratory assist device, bi-level pressure capability, without back-up rate feature, used with non-invasive interface (nasal or facial mask)</td>
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<tr>
<td>E0471</td>
<td>Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with non-invasive interface (nasal or facial mask)</td>
</tr>
<tr>
<td>E0561</td>
<td>Humidifier, non-heated, used with positive airway pressure device</td>
</tr>
<tr>
<td>E0562</td>
<td>Humidifier, heated, used with positive airway pressure device</td>
</tr>
<tr>
<td>A4604</td>
<td>Tubing with heating element</td>
</tr>
<tr>
<td>A7027</td>
<td>Combination Oral/Nasal Mask used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7028</td>
<td>Oral Cushion, Replacement for Combination Oral/Nasal Mask, each</td>
</tr>
<tr>
<td>A7029</td>
<td>Nasal Pillows, Replacement for Combination Oral/Nasal Mask, pair</td>
</tr>
<tr>
<td>A7030</td>
<td>Full Face Mask used with positive airway pressure device, each</td>
</tr>
<tr>
<td>A7031</td>
<td>Face Mask Cushion, Replacement for Full Face Mask</td>
</tr>
<tr>
<td>A7032</td>
<td>Replacement Cushion for Nasal Application Device</td>
</tr>
<tr>
<td>A7033</td>
<td>Replacement Pillows for Nasal Application Device, pair</td>
</tr>
<tr>
<td>A7034</td>
<td>Nasal Interface (mask or cannula type), used with positive airway pressure device, each</td>
</tr>
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with/without head strap

<table>
<thead>
<tr>
<th>A7035</th>
<th>Headgear</th>
</tr>
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<tbody>
<tr>
<td>A7036</td>
<td>Chinstrap</td>
</tr>
<tr>
<td>A7037</td>
<td>Tubing</td>
</tr>
<tr>
<td>A7038</td>
<td>Filter, disposable</td>
</tr>
<tr>
<td>A7039</td>
<td>Filter, non-disposable</td>
</tr>
<tr>
<td>A7044</td>
<td>Oral Interface for Positive Airway Pressure Therapy</td>
</tr>
<tr>
<td>A7045</td>
<td>Replacement Exhalation Port for PAP Therapy</td>
</tr>
<tr>
<td>A7046</td>
<td>Water chamber for humidifier, replacement, each</td>
</tr>
</tbody>
</table>

Description

Bi-level positive airway pressure (BPAP) refers to a ventilation modality whereby different levels of positive airway pressure are applied during inspiration and expiration. BPAP may be administered via a non-invasive interface (whole face mask, nasal mask or nasal cushions) or via an invasive interface (endotracheal intubation or tracheostomy). This guideline is limited to the use of BPAP via non-invasive interface. Furthermore, the guideline refers to the chronic use of BPAP in the outpatient setting rather than acute inpatient use. In addition to providing positive airway pressure which varies from inspiration to expiration, some BPAP machines also have a back-up rate feature. The back-up rate feature ensures that the patient receives a minimum number of breaths per minute. Some patients who are candidates for BPAP may also benefit from the back-up rate feature (see specific indications below).

For patients requiring treatment with BPAP, pressure levels need to be titrated to each patient’s particular needs. For patients whose diagnostic sleep study is performed in a lab setting, it may be possible to diagnose OSA and perform the titration study in a single night. This approach, known as split-night study, may be used when the apnea/hypopnea index (AHI) exceeds 20 per hour based on the first 2 hours of testing. Those who do not meet criteria for split-night protocol require either a second overnight titration study or temporary use of auto-titrating BPAP as a means of BPAP titration. Titration may not be required if auto-titrating BPAP is selected as the long-term therapeutic approach.

As with other positive airway pressure (PAP) therapies, long term compliance is an issue. Adherence to therapy is defined by the Centers for Medicare & Medicaid Services (CMS) as use of PAP greater than or equal to 4 hours per night on 70% of nights during a consecutive thirty (30) day period. Compliance may be as low as 50% at one year and for this reason compliance monitoring is an important component of the management of patients using BPAP. Every effort should be made to achieve compliance. Newer PAP devices record (and may transmit) use times such that compliance monitoring may be performed remotely. Unless compliance is achieved and documented, the continued use of PAP devices (and the ongoing provision of associated supplies) cannot be considered to be medically necessary.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>5/2017</td>
<td>Prior Authorization Information clarified. 5/1/2017</td>
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<tr>
<td></td>
<td>AIM Sleep Disorder Management Diagnostic &amp; Treatment Guidelines. Effective 5/15/2017</td>
</tr>
<tr>
<td>2/2017</td>
<td>BPAP (with back-up rate feature) OSA clarified to CSA. Description clarified. New references added. 2/2/2017</td>
</tr>
<tr>
<td></td>
<td>AIM Sleep Disorder Management Diagnostic &amp; Treatment Guidelines. Effective 1/1/2016.</td>
</tr>
<tr>
<td>9/2014</td>
<td>Clarified coding information.</td>
</tr>
<tr>
<td>5/2014</td>
<td>Clarified coding information.</td>
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1/2013 Updated to add new CPT code 95782 and 95783.


5/2009 Updated prior authorization information.


5/2007 Updated coverage and non coverage guidelines for oral appliances for sleep apnea.


Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

Bibliography
Specialty Society Guidelines and Systematic Reviews


Other Literature

Endnotes

1 Based on AIM Specialty Health: Sleep Disorder Management Diagnostic & Treatment Guidelines Program. Effective May 15, 2017.