CPAP Guidelines

CPAP Updates

✓ The patient’s MEDICAL RECORD MUST CONTAIN sufficient documentation of the patient’s medical condition to substantiate the necessity for the type and quantity of items ordered and MUST BE SIGNED BY THE PRESCRIBING PRACTITIONER.
✓ A Physician, Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) must have a Face-to-Face evaluation with the beneficiary prior to the written Durable Medical Equipment (DME) order and document the Face-to-Face evaluation in the patient’s medical records.
✓ The Face-to-Face evaluation must be signed by a PECOS certified provider.
✓ The Face-to-Face evaluation must occur during the six months prior to the written order for each item.
✓ For CPAP, the evaluation must occur prior to the sleep study.

Written Order Prior to Dispensing (WOPD)
A detailed written order for the item must be received before the delivery of the item can take place and must include minimally the following information:
1. Prescriber’s name
2. Prescribing practitioner’s National Provider Identifier (NPI#)
3. Beneficiary’s name
4. Date of order AND Start date of order
5. Specific DME item ordered and/or accessories
6. Prescribing practitioner’s signature – legible
7. Date of prescriber’s signature

HCPC Code Affected Include the Following
CPAP (E0601) and BiPAP (E0470)

Home Care Medical PAP Checklist
Required Documentation
1. Face-to-Face Requirements/Locally Acceptable Chart Notes - signed and dated by treating practitioner
2. WOPD (Written Order Prior to Dispensing)
3. Signed and Completed CMN with DX of OSA
4. Full Sleep Study (Interpretation and Graphs) - signed and dated by treating practitioner

Initial Coverage Criteria for PAP
A CPAP device is covered for the treatment of obstructive sleep apnea (OSA) if criteria A-C are met:

A. The beneficiary has a Face-to-Face clinical evaluation by the treating physician prior to the sleep test to assess the beneficiary for obstructive sleep apnea.

B. The beneficiary has a sleep test (as defined below) that meets either of the following criteria (1 or 2):
   1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or
   2. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
      ✓ Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
      ✓ Hypertension, ischemic heart disease, or history of stroke.

Documentation in Medical Records Required by CMS

<table>
<thead>
<tr>
<th>Documentation Requirements</th>
<th>Key Items to Address</th>
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</thead>
<tbody>
<tr>
<td>☐ Duration of patient’s condition</td>
<td>☐ Why does the patient require the item?</td>
</tr>
<tr>
<td>☐ Clinical course</td>
<td>☐ Do the physical examination findings support the need for the item?</td>
</tr>
<tr>
<td>☐ Prognosis</td>
<td>☐ Signs and symptoms that indicate the need for the item</td>
</tr>
<tr>
<td>☐ Nature and extent of functional limitations</td>
<td>☐ Diagnoses that are responsible for these signs and symptoms</td>
</tr>
<tr>
<td>☐ Other therapeutic interventions and results</td>
<td>☐ Other diagnoses that may relate to the need for the item</td>
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C. The beneficiary and/or their caregiver has received instruction from the supplier of the device in the proper use and care of the equipment.

If a claim for a CPAP is submitted and all of the criteria above have not been met, it will be denied as not reasonable and necessary.

A BiPAP device is covered for those beneficiaries with OSA who meet criteria A-C above, in addition to criterion D:

D. A CPAP has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting.

If a BiPAP is billed for a beneficiary with OSA and criteria A-D are not met, it will be denied as not reasonable and necessary.

A bi-level positive airway pressure device with back-up rate (BiPAP ST) is not medically necessary if the primary diagnosis is OSA. If a BiPAP ST is billed with a diagnosis of OSA, it will be denied as not reasonable and necessary:

If a CPAP device is tried and found ineffective during the initial facility-based titration or home trial, substitution of a BiPAP does not require a new initial Face-to-Face clinical evaluation or a new sleep test.

If a CPAP device has been used for more than 3 months and the beneficiary is switched to a BiPAP, a new initial Face-to-Face clinical evaluation is required, but a new sleep test is not required. A new 3 month trial would begin for use of the BiPAP.

Replacement PAP – After 5 year reasonable useful lifetime. Patient needs to have a follow-up visit with physician. This visit cannot be for or in conjunction with any other illness or treatment. The Physician must document in the patient’s medical chart that patient continues to use/benefit from the PAP unit. A letter from the physician or prescription pad is not sufficient; the doctor must document the need within the chart notes. A prescription pad may accompany the chart notes indicating the need for the replacement unit. There is no requirement for a new sleep test or trial period.

**Home Care Medical FAQ’s**

1Q. What are the only qualifying diagnosis?

A. The only qualifying diagnosis for dispensing PAP to a patient is OSA. No other diagnosis i.e. Central Sleep Apnea (CSA) qualifies a patient under the PAP policy. (The RAD policy - has additional diagnosis such as CSA to qualify a patient for a Bipap.)

2Q. If PAP is broken, defective, lost or stolen?

A. Broken/Replacing - See 5Q and 6Q. Defective - Contact our Service/Repair department at 800.369.6939 ext 422. Lost/Stolen - Contact our Private Pay department right away to resolve billing/replacement 800.369.6939 ext 206.

3Q. Interruptions due to change in condition or additional diagnoses?

A. If the patient experiences any illnesses or is diagnosed with any additional diagnosis that might interfere or prevent them from using their PAP machine, the patient should contact Home Care Medical’s Respiratory Intake at 800.369.6939 ext 208 to discuss options or alternatives to maintain their use of the unit and comfort level of their equipment.

4Q. Is your patient having issues with unit or supplies (due to weight gain, leaking mask, etc.)?

A. Contact Home Care Medical’s Respiratory Intake at 800.369.6939 ext 207 for pressure settings, leaking masks, etc.

5Q. Can the patient get a replacement unit before the 5 year limit?

A. Contact Home Care Medical’s Service/Repair Department at 800.369.6939 ext 422 to have equipment analyzed for repair.
6Q. How does the patient get a replacement unit after 5 years when the patient HAS met compliance?

A. Reasonable Useful Lifetime (RUL) for Medicare is 5 years. Patient can be considered for new unit after the RUL has been met. Patient needs to have a Face-to-Face eval by their treating physician who DOCUMENTS diagnosis of OSA and indicates they continue to NEED/USE and BENEFIT from the unit prior to dispensing new unit. (No new sleep study is needed - for PAP device.)

7Q. How does the patient get a replacement unit after 5 years when the patient HAS NOT met compliance?

A. RUL for Medicare is 5 years. Patient can be considered for new unit after the RUL has been met. If patient has not met compliance with previous PAP unit, the patient must see prescriber for NEW Face-to-Face - this must document why the patient failed usage the first time. In addition, patient must undergo another sleep study and this sleep study MUST be a facility-based study and not a home study. Patient must meet all guidelines of sleep study.

8Q. How to Convert to Sale (CTS) of the unit?

A. If Home Care Medical receives 13 total payments from Traditional Medicare, the PAP unit will be converted to sale at no charge. Medicare Advantage plans, Commercial, and T19 are subject to contract agreements. For example, UHC pays 10 months; UMR sometimes converts after 2 months with balance billed to insurance or patient depending on deductible and co-insurance met (subject to contract changes). Patient should refer to Explanation of Benefits (EOB) for purchase information on their unit.

Our Requirements

Home Care Medical will NOT deliver or ship any Durable Medical Equipment to Medicare beneficiaries (with all Traditional and Advantage Plans) without receiving the required Face-to-Face documentation and the Written Order.