



Physician documentation for patients with OSA

Required for PAP therapy

For Medicare to cover CPAP therapy for a patient, the durable medical equipment (DME) supplier must have specific documentation that demonstrates the therapy is medically necessary. As the prescriber of therapy, it is important to work with the DME supplier to ensure the supplier has the necessary documentation on file. This tip sheet may help you identify the evaluation criteria and documentation that Medicare requires the DME supplier to have on file to facilitate your patient's access to therapy.

PHILIPS

RESPIRONICS

sense **and** simplicity

I. Initial coverage criteria for CPAP (first three months)

The treating physician must clinically evaluate the patient face-to-face prior to the sleep test to assess the patient for obstructive sleep apnea (OSA). This evaluation will likely include the following parameters:

- a. **Sleep history** – signs and symptoms of sleep-disordered breathing, including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, and morning headaches
- b. **Epworth Sleepiness Scale** – validated sleep hygiene inventory
- c. **Physical examination** – body mass index (BMI), neck circumference, and a focused cardiopulmonary and upper airway system evaluation

In addition to this clinical evaluation, the patient must have a sleep study (Type I, II, III, IV, or other) that documents one of the following:

Medicare-covered sleep test where the apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is ≥ 15 events per hour with a minimum of 30 events



Medicare-covered sleep test where the AHI or RDI is ≥ 5 and ≤ 14 events per hour with a minimum of 10 events and documentation of:

- a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
- b. Hypertension, ischemic heart disease, or history of stroke

This documentation must be made available to the DME supplier who will be providing the positive airway pressure (PAP) equipment to the patient.

Diagnosis – 327.23-Obstructive Sleep Apnea. This is the only qualifying diagnosis per policy.

The sleep test must be performed by an entity qualified to perform sleep tests. The sleep study must be interpreted by a physician with:

- Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or,
- Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or,
- Completed residency or fellowship training by an ABSM member board and completion of all the requirements for subspecialty certification in sleep medicine, except the examination itself and only until the time of reporting of the first examination for which the physician is eligible; or,
- Active staff membership of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations – JCAHO)

II. Continued coverage of CPAP

(beyond first three months)

The treating physician must re-evaluate the patient no sooner than the 31st day and no later than the 91st day after initiating therapy, documenting that the patient is benefiting from therapy. Clinical benefit is documented by:

- Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and,
- Objective evidence demonstrating patient adherence to use of the PAP device (adherence to therapy is defined as **use of PAP \geq 4 hours per night on 70% of nights** during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage); reviewed by the physician

If the patient does **not** meet these requirements, Medicare will deny the therapy as not medically necessary.

The patient may re-qualify for PAP therapy if the:

- Physician re-evaluates the patient face-to-face to determine the etiology of the failure to respond to PAP therapy, and
- A repeat sleep test in a facility-based setting (Type 1 study) is performed

If the patient qualifies for PAP therapy after the above re-qualification, the 90-day trial requirements outlined above must be met for coverage to continue beyond the 90-day trial period.

Documentation required for a RAD device

For Medicare to cover respiratory assist device (RAD) therapy for a patient, there must be documented failure of CPAP therapy, either during an in-lab titration or at home. As the prescriber of therapy, it is important to work with the DME supplier to ensure the supplier has the necessary documentation on file.

Initial coverage criteria for RAD (first three months)

If CPAP therapy has been tried and proven ineffective, RAD therapy may be covered for patients with OSA if the treating physician has documented the following prior to changing from a CPAP device to a RAD device:

An appropriate interface has been properly fit and the beneficiary is using it without difficulty. This properly fit interface will be used with the E0470 device.

The current pressure setting of the E0601 device prevents the beneficiary from tolerating the therapy and lower pressure settings of the E0601 device were tried but failed to:

1. Adequately control the symptoms of OSA; or
2. Improve sleep quality; or
3. Reduce the AHI/RDI to acceptable levels

- If an E0601 device is tried and found ineffective during the initial facility-based titration or home trial, substitution of an E0470 device does not change the length of the trial unless there is less than 30 days remaining in the trial period.

If more than 30 days remain in the trial period, the clinical re-evaluation would still occur between the 31st and 91st day following the initiation of an E0601 device. Also, objective documentation of adherence on the E0470 device would need to occur prior to the 91st day following initiation of the E0601 device.

If less than 30 days remain in the trial period, the clinical re-evaluation and objective documentation of adherence must occur before the 120th day following the initiation of the E0601 device.

- If an E0601 device was used for more than three months and the patient was then switched to an E0470 device, the clinical re-evaluation must occur between the 31st and 91st day following the initiation of the E0470 device. There also would need to be documentation of adherence to therapy during the three month trial with the E0470 device.

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Royal Philips Electronics**

How to reach us

www.philips.com/healthcare
healthcare@philips.com

Asia
+49 7031 463 2254

Europe, Middle East, Africa
+49 7031 463 2254

Latin America
+55 11 2125 0744

North America
+1 425 487 7000
800 285 5585 (toll free, US only)

Philips Respiroics
1010 Murry Ridge Lane
Murrysville, PA 15668

Customer Service
+1 724 387 4000
800 345 6443 (toll free, US only)

Philips Respiroics International
Headquarters
+33 1 47 28 30 82

Philips Respiroics Asia Pacific
+65 6882 5282

Philips Respiroics Australia
+61 (2) 9666 4444

Philips Respiroics China
+86 021 24127311

Philips Respiroics Deutschland
+49 8152 93 06 0

Philips Respiroics France
+33 2 51 89 36 00

Philips Respiroics Italy
+39 039 203 1

Philips Respiroics Sweden
+46 8 120 45 900

Philips Respiroics Switzerland
+41 6 27 45 17 50

Philips Respiroics United
Kingdom
+44 800 1300 845

www.philips.com/respiroics

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CAUTION: US federal law restricts these devices to sale by or on the order of a physician.

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