



# DETAILED WRITTEN ORDER

Homecare Dimensions

Document #: **09.DWO.HCD.02b**  
Effective: **09/15/2009**

Rev.: **B**

Title: **Positive Airway Pressure Devices**  
E0470, E0471, E0601, E0561, E0562

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Initial Date of Medical Necessity: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ DOB: \_\_\_\_\_

Email: \_\_\_\_\_ Length of Need: \_\_\_\_\_ (99 = Lifetime)

Diagnosis Code: \_\_\_\_\_

**Medical Records:** The patient's medical record, **to be supplied with this order**, must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The Medical Records **must** include a copy of:

- The patient's initial face-to-face clinical evaluation prior to the sleep test.
- The patient's Overnight Sleep test.

If you are ordering a RAD Respiratory Assistance Device (RAD) and the patient meets the criteria for a CPAP, the Medical Records must document that the CPAP has been tried and proven **ineffective** based on a therapeutic trial conducted in either a facility or in a home setting. Documentation must be provided at time of the order.

For continued use after the trial period, the Medical Records must document that a clinical re-evaluation by the treating provider occurred no sooner than the 31st day but no later than the 91st day after initiating therapy.

The patient is scheduled for a follow-up clinical evaluation on: \_\_\_\_\_

The re-evaluation must document both improvements in subjective symptoms of OSA and objective data related to adherence to PAP therapy.

**Equipment Ordered:** All PAPs and accessories are billed using the specific codes listed in the Local Coverage Determination.

ORDERED	CODE	QUANTITY	DETAILED DESCRIPTION OF ORDERED ITEMS
	<b>E0601</b>		Continuous airway pressure (CPAP) device
	<b>E0470</b>		Respiratory assist device, bi-level pressure capability, without backup rate feature,
	<b>E0471</b>		Respiratory assist device, bi-level pressure capability, with back-up rate feature
	<b>E0561</b>		Humidifier, non-heated, used with positive airway pressure device
	<b>E0562</b>		Humidifier, heated, used with positive airway pressure device
	<b>A4604</b>	1 per month	Tubing with integrated heating element for use with positive airway pressure device
	<b>A7027</b>	1 per 3 months	Combination oral/nasal mask, used with CPAP device, each
	<b>A7028</b>	2 per month	Oral cushion for combination oral/nasal mask, replacement only, each
	<b>A7029</b>	2 per month	Nasal pillows for combination oral/nasal mask, replacement only, pair
	<b>A7030</b>	1 per 3 months	Full face mask used with positive airway pressure device, each
	<b>A7031</b>	1 per month	Face mask interface, replacement for full face mask, each
	<b>A7032</b>	2 per month	Cushion for use on nasal mask interface, replacement only, each
	<b>A7033</b>	2 per month	Pillow for use on nasal cannula type interface, replacement only, pair
	<b>A7034</b>	1 per 3 months	Nasal interface used with positive airway pressure device, with or without head strap



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ORDERED	CODE	QUANTITY	DETAILED DESCRIPTION OF ORDERED ITEMS
	A7035	1 per 6 months	Headgear used with positive airway pressure device
	A7036	1 per 6 months	Chinstrap used with positive airway pressure device
	A7037	1 per 3 months	Tubing used with positive airway pressure device
	A7038	2 per month	Filter, disposable, used with positive airway pressure device
	A7039	1 per 6 months	Filter, non disposable, used with positive airway pressure device
	A7046	1 per 6 months	Water chamber for humidifier, used with positive airway pressure device, replacement, each

Treating Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Treating Physician Name: \_\_\_\_\_

NPI: \_\_\_\_\_

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### Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

**Face-to-Face Clinical Evaluation:** Treating physician's records include a face-to-face clinical evaluation, performed **prior** to the sleep test and documented in a detailed narrative note in the patient's chart in the format the physician used for other entries, that contains pertinent information about the following elements:

**History:**

- Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches;
- Duration of symptoms
- Validated sleep hygiene inventory such as the Epworth Sleepiness Scale

**Physical Exam:**

- Focused cardiopulmonary and upper airway system evaluation
- Neck circumference
- Body mass index (BMI)

**Medicare-covered Sleep Test:** The sleep test may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment. If the AHI or RDI is calculated based on **less than** two hours of sleep or recording time, the total number of recorded events used to calculate the AHI or RDI **must be** at least the number of events that would have been required in a two hour period.

Medicare-covered sleep test that meets all of the following qualifications:

- Performed at a facility-based sleep laboratory
- Test was ordered by the beneficiary's treating physician
- Test was conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements
- Includes sleep staging (a 1-4 lead electroencephalogram [EEG], electro-oculogram [EOG], submental electromyogram [EMG] and electrocardiogram [ECG])
- Also includes at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry

The sleep test results meet either of the follow criteria:

- 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**,
- 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.

The patient and/or their caregiver received instruction from the supplier of the PAP device and accessories in the proper use and care of the equipment

**Claims for Non-Heated or Heated Humidifier (E0561, E0562):**

- Beneficiary meets PAP coverage criteria
- Written order that includes an order for the type of humidification provided

**Continued Coverage (Beyond the First Three Months of Therapy):**

- The treating physician's records document a clinical re-evaluation no sooner than the 31st day but no later than the 91st day after initiating therapy and the re-evaluation supports:
  - The symptoms of obstructive sleep apnea are improved; and
  - The treating physician has reviewed objective evidence (direct download or visual inspection of usage data) that the beneficiary has used PAP > 4 hours per night on 70% of nights during a consecutive 30 day period anytime during the first three months of initial usage.

**End of Document**