



Medicare Policy for Treatment of OSA

(CMS Revision Effective Date: 7/1/2016)

CPAP Qualifications (E0601)

Patient must meet **all** the following criteria to qualify for an E0601 device (**CPAP**)

- Patient has had a **face-to-face clinical evaluation** by treating physician prior to sleep test. See back for additional information.¹
- Patient has had a **Medicare-covered sleep test** that meets either of the following criteria:²
 - a. AHI/RDI³ is ≥ 15 events per hour with a minimum of 30 events; **or**,
 - b. AHI/RDI is ≥ 5 and ≤ 14 events per hour with a minimum of 10 events and documentation of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia, hypertension, ischemic heart disease or history of stroke. See back for additional information.
- Diagnosed with obstructive sleep apnea (OSA) (ICD-9 code 372.23 or ICD-10 code G47.33)
- Patient and/or caregiver has received instruction** from the supplier of the CPAP device and accessories in the proper use and care of the equipment.



Bilevel Qualifications (E0470)

(Follow for CPAP to bilevel conversion)

Patient must meet **all** the following criteria to qualify for an E0470 device (**bilevel without a backup rate**)

- Patient is **qualified for E0601 (CPAP)**
- Treating physician documented that both of the following issues were addressed** prior to changing a patient from an E0601 to an E0470 device due to ineffective therapy:
 - a. An appropriate interface has been properly fitted and the beneficiary is using it without difficulty. The properly fitted interface will be used with the E0470 device; **and**
 - b. The current pressure setting of the E0601 prevents the beneficiary from tolerating the therapy, and lower pressure settings of the E0601 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.

- | | | |
|------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has CPAP been used < 3 months? (i.e. CPAP was tried and found ineffective during the initial 3-month home trial) |
|------------------------------|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------|

If "No," a new initial face-to-face clinical evaluation is required, but not a new sleep test. A new 3-month trial would begin for use of the bilevel. See back for additional information.

If "Yes," the patient is qualified for an E0470 device (bilevel without a backup rate, such as the AirCurve™ 10 VAuto). See back for additional information.

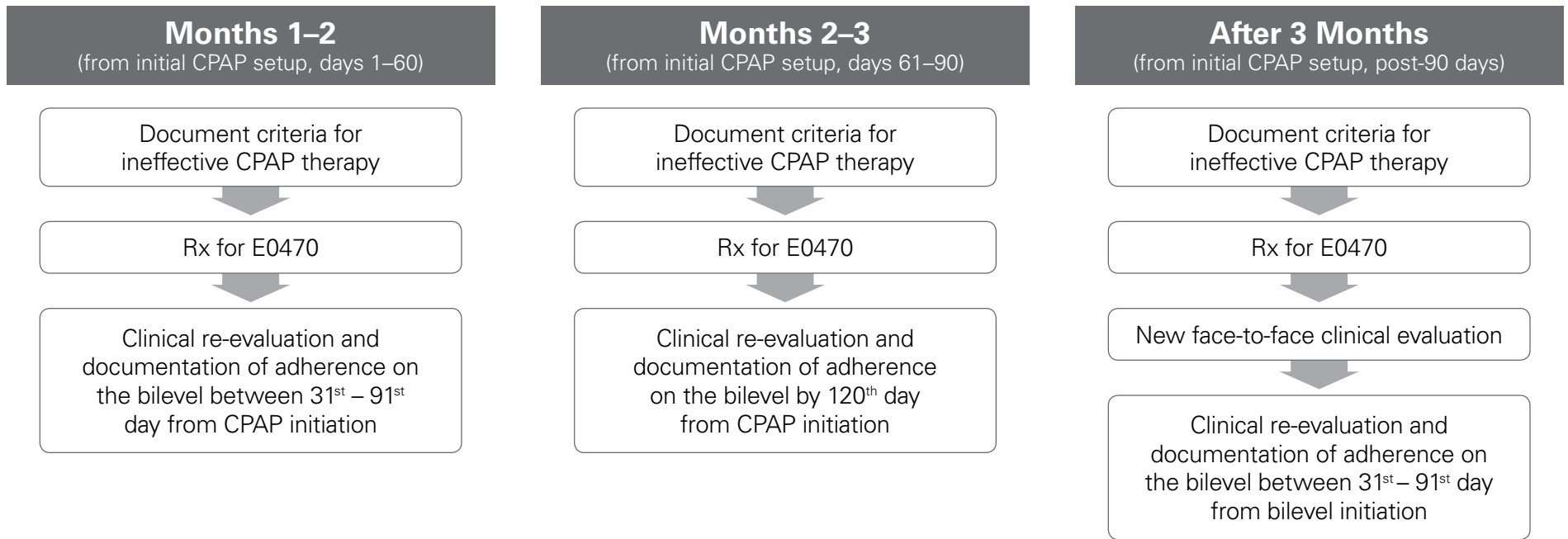


Documentation for Continued Coverage⁴

(For continuing to bill months 4–13)

- Between the 31st and 91st day, treating physician has a face-to-face clinical re-evaluation with patient documenting that symptoms of OSA improved.
- Objective evidence of adherence to use of the positive airway pressure (PAP) device reviewed by treating physician. (Adherence is defined as use of PAP ≥ 4 hours per night on 70% of nights during a consecutive 30-day period anytime during the first 3 months of initial usage.)

Bilevel Conversion Pathways



1 Face-to-face clinical evaluation may include sleep history and symptoms of OSA, Epworth Sleepiness Scale and physical exam documenting body mass index, neck circumference and a focused cardiopulmonary and upper airway evaluation. Some of these elements, in addition to other details, must be documented in patient charts. Each element would not have to be addressed in every evaluation.

2 Medicare-covered sleep tests include Type I, Type II, Type III and Type IV (must monitor and record a minimum of three (3) channels). All sleep tests must be interpreted by a physician who holds either: 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 ABMS member board and has completed 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), Accreditation Commission for Health Care (ACHC) or The Joint Commission (TJC, formerly the Joint Commission on Accreditation of Healthcare Organizations – JCAHO).

3 AHI is defined as the average number of episodes of apnea and hypopnea per hour of sleep. **RDI** is defined as the average number of apneas plus hypopneas per hour of recording.

4 If the patient fails the 12-week trial:

Beneficiaries requalify for a positive airway pressure device with both:

- Face-to-face clinical re-evaluation by treating physician to determine etiology of failure to respond to positive airway pressure therapy; and
- Repeat sleep test in a facility-based setting (Type 1 study).

This information is provided as of the date listed and all coding and reimbursement information is subject to change without notice. It is the provider's responsibility to verify coding and coverage with payors directly. For a full description of the policy go to www.cms.hhs.gov. To contact the ResMed reimbursement hotline, dial 1-800-424-0737 and select option 4.

ResMed.com