



PAP DEVICE FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA

Pap device

The following documentation is required to be in clinic visit/therapy notes from the treating provider within 12 months of the prescription for consideration of payment.

The following documentation is required by Medicare to be in clinic visit note for consideration of payment. Documentation from the medical record should indicate the diagnosis responsible for the needed equipment and support all of the following criteria:

The term PAP (positive airway pressure) device will refer to both a single-level continuous positive airway pressure device (E0601) and a bi-level respiratory assist device without back-up rate (E0470) when it is used in the treatment of obstructive sleep apnea.

An E0601 device is covered for the treatment of obstructive sleep apnea (OSA) if criteria A to 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 (one or two):
 - 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 five and less than or equal to 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.
- 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.

An E0470 device is covered for those beneficiaries with OSA who meet criteria A-C above, in addition to criterion D

- D. An E0601 has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting.

Continued coverage beyond the first three months of therapy

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 31st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

Our Locations

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For PAP devices with initial dates of service on or after November 1, 2008, documentation of clinical benefit is demonstrated by:

1. Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and,
2. Objective evidence of adherence to use of the PAP device, reviewed by the treating physician.

Adherence to therapy is defined as use of PAP \geq four hours per night on 70 percent of nights during a consecutive thirty day period anytime during the first three months of initial usage.

Beneficiaries who fail the initial 12-week trial are eligible to re-qualify for a PAP device but must have both:

1. Face-to-face clinical re-evaluation by the treating physician to determine the etiology of the failure to respond to PAP therapy; and,
2. Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split-night study.

Beneficiaries Entering Medicare

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement PAP device and/or accessories, both of the following coverage requirements must be met:

1. Sleep test - There must be documentation that the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets the Medicare AHI/RDI coverage criteria in effect at the time that the beneficiary seeks Medicare coverage of a replacement PAP device and/or accessories; and,
2. Clinical evaluation - following enrollment in FFS Medicare, the beneficiary must have a face-to-face evaluation by their treating physician who documents in the beneficiary's medical record that:
 - A. The beneficiary has a diagnosis of obstructive sleep apnea; and,
 - B. The beneficiary continues to use the PAP device.

If either criteria 1 or 2 above are not met, the claim will be denied as not reasonable and necessary.