

Reimbursement Fast Facts

This tool will assist you in understanding Medicare coding and coverage for respiratory assist devices



Respiratory assist devices (RADs) are used to administer noninvasive positive pressure therapy, sometimes referred to as NPPV. ResMed's VPAP™ series of products combines increased comfort with a high level of clinical control to help meet the unique needs of every patient. *Bilevel to treat OSA and noncompliant CPAP is covered under a separate policy. See ResMed Reimbursement Fast Facts for CPAP and Bilevel Devices to Treat OSA PN 1013493.*

Device	Description	HCPCS	Medicare Reimbursement ¹
Bilevel	Bilevel devices without a backup rate (eg, VPAP Auto, VPAP S)	E0470	\$231.99-197.19 ² (monthly rate)
Bilevel with backup rate	Bilevel devices with a backup rate (eg, VPAP ST, VPAP Adapt SV, VPAP III ST-A)	E0471	\$580.58-493.49 ² (monthly rate)

Billing Criteria for RADs

Medicare has specific coverage criteria for those patients with clinical disorder groups characterized as follows in the three groups below. Please refer to the local coverage policy for additional details.³

Restrictive Thoracic Disorders

- A.** Documentation in patient's medical record of a neuromuscular disease (eg, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (eg, post-thoracoplasty for TB); and
- B.** An arterial blood gas PaCO₂, done while awake and breathing the patient's FiO₂, is ≥ 45 mm Hg; or sleep oximetry demonstrates oxygen saturation ≤ 88% for ≥ 5 minutes (minimum 2-hour recording time), done while breathing the patient's prescribed FiO₂; or for a neuromuscular disease (only), maximal inspiratory pressure is < 60 cm H₂O or forced vital capacity is < 50% predicted; and
- C.** COPD does not contribute significantly to the patient's pulmonary limitation.

If all of the above criteria are met, either an E0470 or E0471 (based upon the judgment of the treating physician) will be covered for patients within this group of conditions for the first three months of therapy.

Severe COPD

- A.** An arterial blood gas PaCO₂, done while awake and breathing the patient's prescribed FiO₂, is ≥ 52 mm Hg; and
- B.** Sleep oximetry demonstrates oxygen saturation ≤ 88% for ≥ 5 minutes (minimum 2-hour recording time), done while breathing oxygen at 2 LPM or the patient's prescribed FiO₂ (whichever is higher); and
- C.** Prior to initiating therapy, obstructive sleep apnea (OSA) and treatment with continuous positive airway pressure (CPAP) has been considered and ruled out.

If all above criteria are met, an E0470 device will be covered for the first three months of therapy.

An E0471 device will be covered for a patient with COPD if additional criteria are met. Please see continued coverage information in the extended policy for qualification prior to and post 61 days.

Central Sleep Apnea or Complex Sleep Apnea

Prior to initiating therapy, a complete facility-based, attended PSG must be performed documenting the following:

- A.** The diagnosis of central sleep apnea (CSA)⁴ or complex sleep apnea (CompSA); and

- B.** Significant improvement of the sleep-associated hypoventilation with the use of an E0470 or E0471 device on the settings that will be prescribed for initial use at home, while breathing the patient's usual FiO_2 .

If all above criteria are met, either an E0470 or E0471 device (based upon the judgment of the treating physician) will be covered for patients with documented CSA or CompSA for the first three months.

Hypoventilation Syndrome

An E0470 device is covered if the following are met:

1. An initial arterial blood gas PaCO_2 , done while awake and breathing the patient's prescribed FiO_2 , is ≥ 45 mm Hg; and
2. Spirometry shows $\text{FEV1}/\text{FVC} \geq 70\%$ and an $\text{FEV1} \geq 50\%$ of predicted; and
3. An arterial blood gas PaCO_2 , done during sleep or immediately upon awakening, and breathing the patient's prescribed FiO_2 , shows the beneficiary's PaCO_2 worsened ≥ 7 mm Hg compared to original result; or
4. A facility-based PSG demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum 2-hour recording time) not caused by obstructive upper airway events (ie, AHI less than 5).

Q & A

Q: Are RAD devices paid as capped rental items?

Yes, as of April 1, 2006, you must bill NPPV devices as capped rental items. CMS moved them from the frequent and substantial servicing category to the capped rental category. Note: Now that RADs are considered capped rental items, bill accessories (such as masks, cushions, filters and tubing) separately.

Q: What is the appropriate diagnosis code for complex sleep apnea?

Complex sleep apnea is a recently recognized form of CSA. Therefore, diagnoses will fall under existing ICD-9 diagnosis codes for CSA (ie, 327.21 Primary Central Sleep Apnea).

- 1 The rates listed are based on the Medicare 2011 DMEPOS National Fee Schedule. Competitive bidding rates may be applicable in certain CBAs. Please reference the single payment amounts for these areas.
- 2 2011 Medicare ceiling and floor rates; rate reduces by 25% after the third month; payment over 13 months. Actual allowables vary by state.
- 3 Centers for Medicare & Medicaid Services, "LCD for Respiratory Assist Devices (L11504, L5023, L11493)," U.S. Department of Health and Human Services, (revision effective date 2/4/2011).
- 4 Central sleep apnea (CSA) is defined as: (1) an apnea-hypopnea index greater than 5; and (2) central apneas/hypopneas greater than 50% of the total apneas/hypopneas; and (3) central apneas or hypopneas greater than or equal to 5 times per hour; and (4) symptoms of either excessive sleepiness or disrupted sleep. Complex sleep apnea (CompSA) is a form of central apnea specifically identified by the persistence or emergence of central apneas or hypopneas upon exposure to CPAP or an E0470 device when obstructive events have disappeared. These patients have predominantly obstructive or mixed apneas during the diagnostic sleep study occurring at greater than or equal to 5 times per hour. With use of a CPAP or E0470, they show a pattern of apneas and hypopneas that meets the definition of CSA described above.

An E0471 device is covered if the following criteria are met:

- A.** A covered E0470 is being used.
- B.** Spirometry shows $\text{FEV1}/\text{FVC} \geq 70\%$ and an $\text{FEV1} \geq 50\%$ of predicted; and
- C.** An arterial blood gas PaCO_2 , done while awake and breathing the patient's prescribed FiO_2 , shows the beneficiary's PaCO_2 worsened ≥ 7 mm Hg compared to ABG result used to qualify for E0470; or
- D.** A facility-based PSG demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum 2-hour recording time) not caused by obstructive upper airway events (ie, AHI less than 5), while using an E0470.

Follow-up Documentation Requirements

Continued Coverage for E0470 and E0471 Devices Beyond First Three Months of Therapy

The following items must be obtained no sooner than 61 days after initiating use of the device to document continued coverage beyond three months:

1. Signed and dated statement completed by treating physician declaring that the patient is compliant, using the device an average of four hours per 24-hour period, and that the patient is benefiting from its use; and
2. Progress of relevant symptoms.

Q: Is OSA a covered diagnosis for a bilevel with backup rate, E0471?

No, patients cannot qualify for a bilevel with backup rate device with an OSA diagnosis. An OSA diagnosis qualifies a patient for a CPAP (E0601) or bilevel (E0470) with appropriate documentation.

Q: Is a download required to demonstrate continued coverage after 90 days for a RAD device?

For bilevel (E0470) and bilevel with backup rate (E0471) to treat restrictive thoracic disorders, COPD and CSA/CompSA, the only two items required by Medicare policy is a signed and dated statement by the physician and progress of relevant symptoms. A download is not specifically cited as required.

Additional or Related ResMed Support Tools

RAD Qualifying Guidelines PN 1010293
VPAP Adapt SV Coding Flowchart PN 1011264

The information provided with this notice is general reimbursement information only as of January 1, 2011. It is not legal advice, nor is it advice about how to code, complete or submit any particular claim for payment. Although we supply this information to the best of our current knowledge, it is always the provider's responsibility to determine and submit appropriate codes, charges, modifiers and bills for the services that were rendered. This information is provided as of the date listed above, and all coding and reimbursement information is subject to change without notice.