

***RESMED***

**2009**

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**Reimbursement  
Handbook**

**NOTE:**

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# **Understanding Reimbursement**

Developed in 1983 by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), HCPCS (HCFA's Common Procedural Coding System) provides a standardized system for billing Medicare for supplies, materials, and injections. HCPCS consists of three levels: Level I CPT Codes, Level II National Codes, and Level III Local Codes. HCPCS codes must be used when billing Medicare carriers and, in some states, when billing Medicaid carriers. With the implementation of HIPAA, payors are required to utilize standardized code sets. HCPCS are now the standard code set to be used for billing durable medical equipment (DME) for all payors.

## **Level I Codes**

HCPCS mainly consists of CPT (Current Procedural Terminology) codes. These five-digit codes provide a standardized means of reporting services or procedures performed by a physician.

## **Level II Codes**

Level II codes cover supplies, materials, injections, and those services not covered in Level I. Most DME products, including those used in the treatment of obstructive sleep apnea (OSA), are billed with a Level II code.

## **DME MACs**

CMS requires that all claims for DME products and supplies be processed through one of four contracted DME MACs (Durable Medical Equipment Medicare Administrative Contractors) utilizing HCPCS Level II codes and modifiers. The beneficiary's residence determines which DME MAC processes the claim.

## **DME MAC Assignments**

### **Jurisdiction A** (Northeast):

National Heritage Insurance Corp.

DME-Written Inquiries

PO Box 9146

Hingham, MA 02043-9146

Phone: 866-419-9458

[www.medicarenhic.com](http://www.medicarenhic.com)

**Covers:** Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

### **Jurisdiction B** (Midwest):

National Government Services

P.O. Box 6036

Indianapolis, IN 46206-6036

Phone: 877-299-7900

[www.ngsmedicare.com](http://www.ngsmedicare.com)

**Covers:** Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin

### **Jurisdiction C** (South/Southwest):

CIGNA Government Services

P.O. Box 20010

Nashville, TN 37202

Phone: 866-238-9650

[www.cignagovernmentservices.com](http://www.cignagovernmentservices.com)

**Covers:** Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, West Virginia

### **Jurisdiction D** (West)

Noridian Administrative Services

PO Box 6727

Fargo, ND 58108-6727

Phone: 877-320-0390

[www.noridianmedicare.com](http://www.noridianmedicare.com)

**Covers:** Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, Wyoming

**Visit [www.cms.gov](http://www.cms.gov) to obtain Medicare Part A/B contractors by state.**

## 2009 Sleep-Related HCPCS Codes and DMEPOS Fee Schedule

CODE	MODIFIERS	HCPCS DESCRIPTION	CMS REIMBURSEMENT	
			CEILING	FLOOR
A4604	NU	Tubing with integrated heating element for use with positive airway pressure (PAP) device	\$60.46	\$51.39
A7027	NU	Combination oral/nasal mask, used with continuous positive airway pressure device, each	195.85	166.47
A7028	NU	Oral cushion for combination oral/nasal mask, replacement only, each	52.02	44.22
A7029	NU	Nasal pillows for combination oral/nasal mask, replacement only, pair	21.25	18.06
A7030	NU	Full face mask used with PAP device, each	\$170.72	\$145.11
A7031	NU	Face mask interface, replacement for full face mask, each	\$63.14	\$53.67
A7032	NU	Cushion for use on nasal mask interface, replacement only, each	\$36.68	\$31.18
A7033	NU	Pillow for use on nasal cannula type interface, replacement only, pair	\$25.71	\$21.85
A7034	NU	Nasal interface (mask or cannula type) used with PAP device, with or without head strap	\$106.46	\$90.49
A7035	NU	Headgear used with PAP device, each	\$35.97	\$30.57
A7036	NU	Chinstrap used with PAP device	\$16.47	\$14.00
A7037	NU	Tubing used with PAP device	\$37.12	\$31.55
A7038	NU	Filter, disposable, used with PAP device	\$4.88	\$4.15
A7039	NU	Filter, non-disposable, used with PAP device	\$13.87	\$11.79
A7044	NU	Oral interface, used with PAP device, each	\$109.42	\$93.01
A7045	NU	Exhalation port with or without swivel used with accessories for PAP devices, replacement only	\$17.62	\$14.98
A7046	NU	Replacement water chamber for humidification used with positive airway pressure device	\$17.66	\$15.01
A9279	—	Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified	<i>No Current Fee Schedule</i>	
A9999	NU	Misc. DME supply or accessory not otherwise specified.	Contractor Priced	Contractor Priced

**RR = Rental Equipment**  
**NU = New Equipment**  
**UE = Used Equipment**

CODE	MODIFIERS	HCPCS DESCRIPTION	CMS REIMBURSEMENT	
			CEILING	FLOOR
E0470	RR	Respiratory assist device, bilevel pressure capability, without backup rate feature, used with noninvasive interface, eg, nasal or facial mask	\$232.22	\$197.39
E0471	RR	Respiratory assist device, bilevel pressure capability, with backup rate feature, used with noninvasive interface, eg nasal or facial mask	\$581.16	\$493.99
E0472	RR	Respiratory assist device, bilevel pressure capacity, with back up rate feature, used with invasive interface, eg tracheostomy tube	\$581.16	\$493.99
E0561	NU	Humidifier, non-heated, used with PAP device	\$96.84	\$82.31
E0561	UE	Humidifier, non-heated, used with PAP device	\$72.62	\$61.73
E0561	RR	Humidifier, non-heated, used with PAP device	\$9.67	\$8.22
E0562	NU	Humidifier, heated, used with PAP device	\$272.60	\$231.71
E0562	UE	Humidifier, heated, used with PAP device	\$204.45	\$173.78
E0562	RR	Humidifier, heated, used with PAP device	\$27.25	\$23.16
E0601	RR	Continuous positive airway pressure (CPAP) device	\$101.10	\$85.94
E1399		Durable medical equipment, miscellaneous	Contractor Priced	Contractor Priced

## Recommended Replacement Schedule Allowable for Accessories

This section discusses recommended replacement schedule allowables for accessories used in conjunction with positive airway pressure (PAP) devices, specifically CPAP (E0601) RAD bilevel without backup rate (E0470) and RAD bilevel with backup rate (E0471). These devices fall into the capped rental category; therefore, accessories used with these devices can be provided to the patient when medically necessary and billed according to the information below.

<b>Code</b>	<b>Accessory Description</b>	<b>Recommended Replacement Schedule</b>
<b>A7027</b>	Combination oral/nasal mask	1 per 3 months
<b>A7028</b>	Oral cushion for combination oral/nasal mask - Replacement	2 per 1 month
<b>A7029</b>	Nasal pillows for combination oral/nasal mask - Replacement	2 per 1 month
<b>A7030</b>	Full face mask	1 per 3 months
<b>A7031</b>	Face mask interface replacement, each	1 per 1 month
<b>A7032</b>	Replacement nasal cushion	2 per 1 month
<b>A7033</b>	Replacement pillows	2 pair per 1 month
<b>A7034</b>	Nasal interface (mask or cannula type) used with PAP device	1 per 3 months
<b>A7035</b>	Headgear, used with PAP device	1 per 6 months
<b>A7036</b>	Chin strap, used with PAP	1 per 6 months
<b>A7037</b>	Tubing, used with PAP device	1 per 3 months
<b>A7038</b>	Filter, disposable, used with PAP	2 per 1 month
<b>A7039</b>	Filter, non-disposable, used with PAP	1 per 6 months
<b>A7046</b>	Humidifier chamber replacement, each	1 per 6 months
<b>A9279</b>	Monitoring feature/device	contact payor

## ResMed Products and Applicable HCPCS Codes

PRODUCT NAME	RESMED PART #(s)	HCPCS CODE
AutoSet Spirit	30001	E0601
C-Series Heated Humidifier	34900	E0562
C-Series Tango	34000	E0601
HumidAire 2i	30902	E0562
HumidAire 2iC Passive Humidifier	30927	E0561
HumidAire 3i	33906	E0562
HumidAire 4i	26940	E0562
Meridian Nasal Mask	61102, 61103	A7034+A7035
Meridian Headgear	61117	A7035
Mirage Activa Cushions	60117, 60118, 60119	A7032
Mirage Activa Headgear	1118, 16119, 60114	A7035
Mirage Activa Nasal Mask	60100, 60101, 60102	A7034+A7035
Mirage Activa LT Nasal Mask	60148, 60149, 60150	A7034+A7035
Mirage Activa LT Nasal Cushion	60177, 60178, 60179	A7032
Mirage and Ultra Mirage Nasal Headgear	16117, 16118, 16119	A7035
Mirage Kidsta Headgear	61020	A7035
Mirage Kidsta Nasal Cushion	60013	A7032
Mirage Kidsta Nasal Mask	61010	A7034+A7035
Mirage Liberty Headgear	61348, 61349	A7035
Mirage Liberty Mask	61300, 61301	A7027+A7035
Mirage Liberty Nasal Pillows	61333, 61334, 61335	A7029
Mirage Liberty Oral Cushion	61330, 61331	A7028
Mirage Micro Nasal Mask	16333, 16334, 16335	A7034+A7035
Mirage Micro Nasal Cushion	16388, 16389, 16390, 16391, 16392	A7032
Mirage Quattro Full Face Mask	61200, 61201, 61202, 61203	A7030+A7035
Mirage Quattro Full Face Mask Cushions	61290, 61291, 61292, 61293	A7031

## ResMed Products and Applicable HCPCS Codes

PRODUCT NAME	RESMED PART #(s)	HCPCS CODE
Mirage Swift Headgear	60526	A7035
Mirage Swift Nasal Pillow II Sleeve	60541. 60542. 60543	A7033
Mirage Swift Nasal Pillow II System	60512	A7034+A7035
Mirage Swift Nasal Pillow Sleeve	60520, 60521, 60522	A7033
Mirage Swift Nasal Pillow System	60505	A7034+A7035
Mirage Vista Nasal Mask	60000, 60001	A7034+A7035
Mirage Vista Headgear	60918	A7035
Mirage Vista Nasal Cushions	60921, 60922	A7032
ResLink	22206+22212+30942(S8) 30921+22212+30942 (S7)	A9279
ResScan	22903+22207+31301	A9279
ResTraxx	22204, 30905	A9279
S7 Elite	30002	E0601
S7 Lightweight	30011	E0601
S8 AutoSet Vantage with ResScan Data Card	33112	E0601+A9279
S8 AutoSet Vantage	33112	E0601
S8 Compact	33030	E0601
S8 AutoSet II	33129	E0601+A9279
S8 AutoSet II and H4i	33150	E0601+A9279+E0562
S8 Elite	33021	E0601
S8 Elite with ResScan Data Card	33021	E0601+A9279
S8 Elite II	33039	E0601+A9279
S8 Elite II and H4i	33062	E0601+A9279+E0562

## ResMed Products and Applicable HCPCS Codes

PRODUCT NAME	RESMED PART #(s)	HCPCS CODE
S8 Escape	33007	E0601
S8 Escape and H4i	33060	E0601+A9279+E0562
S8 Escape with ResScan Data Card	33007	E0601+A9279
S8 Escape II	33051	E0601+A9279
S8 Escape II and H4i	33061	E0601+A9279+E0562
Swift LT Nasal Pillow System	60560	A7034+A7035
Swift LT Headgear	60578	A7035
Swift LT Nasal Pillow	60571, 60572, 60573, 60574	A7033
Swift LT for Her Nasal Pillow System	60588	A7034+A7035
Swift LT for Her Headgear	60595	A7035
Ultra Mirage Full Face Mask	60600-60605	A7030+A7035
Ultra Mirage Full Face Mask - Cushions	16604, 16605, 16606, 16671, 16672, 16673	A7031
Ultra Mirage Full Face Mask/Mirage Quattro Headgear	16118, 16119, 60674	A7035
Ultra Mirage II Nasal Cushions	16556, 16557, 16558, 16735	A7032
Ultra Mirage II Nasal Mask	16548, 16549, 16550, 16577	A7034+A7035
VPAP Adapt SV	26013	E0471
VPAP Auto 25	26101	E0470+A9279
VPAP Auto 25 and H4i	26121	E0470+A9279+E0562
VPAP III	24101	E0470
VPAP S	26119	E0470+A9279
VPAP S and H4i	26120	E0470+A9279+E0562
VPAP ST	26110	E0471+A9279
VPAP ST and H4i	26122	E0471+A9279+E0562
VPAP ST-A	24116	E0471
VPAP Malibu	26201	E0470

# Medicare Coverage for PAP Devices for the Treatment of OSA

Policy revised September 18, 2008

A single level continuous positive airway pressure (CPAP) device (E0601) is covered for the treatment of obstructive sleep apnea (OSA) if criteria A - C are met:

- A. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea.

NOTE: Physicians shall document the face-to-face clinical evaluations and re-evaluations in a detailed narrative note in their charts in the format that they use for other entries. For the initial evaluation, the report would commonly document pertinent information about the following elements (history and physical exam), but may include other details.

- B. The patient has a Medicare-covered sleep test that meets either of the following criteria (1 or 2):
  - 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 5 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 patient and/or their caregiver has received instruction from the supplier of the CPAP device and accessories in the proper use and care of the equipment.

If a claim for a CPAP (E0601) is submitted and all of the criteria above have not been met, it will be denied as not medically necessary.

Apnea is defined as the cessation of airflow for at least 10 seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds associated with at least a 30% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4% decrease in oxygen saturation.

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apnea and hypopnea per hour of sleep without the use of a positive airway pressure device.

\*The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device.

If the AHI or RDI is calculated based on less than 2 hours of sleep or recorded time, the total number of recorded events used to calculate the AHI or RDI (respectively) must be at least the number of events that would have been required in a 2 hour period (i.e., must reach  $\geq 30$  events without symptoms or  $\geq 10$  events with symptoms).

#### Respiratory Assist Devices (RAD)

A RAD without backup rate (E0470) is covered for those patients with OSA who meet criteria A-C above, in addition to criterion D

- D. A single level (E0601) positive airway pressure device has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or in a home setting.

If E0470 is billed and criterion D is not met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601.

If a CPAP device is tried and found ineffective during the initial 3 month home trial, substitution of a RAD does not require a new initial face-to-face clinical evaluation or a new sleep test.

If a CPAP device has been used for more than 3 months and the patient is switched to a RAD, a new initial face-to-face clinical evaluation is required, but a new sleep test is not required. A new 3 month trial would begin for use of the RAD.

#### Sleep Tests

A Type I sleep test is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It is facility-based and must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), electro-oculogram (EOG), submental electromyogram (EMG) and electrocardiogram (ECG). It must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment.

An HST is performed unattended in the beneficiary's home using a portable monitoring device. A portable monitoring device for conducting an HST must meet one of the following criteria:

- A. Type II device – Monitors and records a minimum of seven (7) channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory movement/effort and oxygen saturation; or,
- B. Type III device – Monitors and records a minimum of four (4) channels: respiratory movement/effort, airflow, ECG/heart rate and oxygen saturation; or,

- C. Type IV device – Monitors and records a minimum of three (3) channels that allow direct calculation of an AHI or RDI as defined above. Devices that record channels that do not allow direct calculation of an AHI or RDI may be considered as acceptable alternatives if there is substantive clinical evidence in the published peer-reviewed medical literature that demonstrates that the results accurately and reliably correspond to an AHI or RDI.

For PAP devices with initial dates of service on or after November 1, 2008, all beneficiaries who undergo an HST must, prior to having the test, receive instruction on how to properly apply a portable sleep monitoring device. This instruction must be provided by the entity conducting the HST and may not be performed by a DME supplier. Patient instruction may be accomplished by either:

1. Face-to-face demonstration of the portable sleep monitoring device's application and use; or,
2. Video or telephonic instruction, with 24 hour availability of qualified personnel to answer questions or troubleshoot issues with the device.

For PAP devices with initial dates of service on or after November 1, 2008, all HSTs (Type II, III, or IV) must be interpreted by a physician who holds either:

1. Current certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM); or,
2. Current subspecialty certification in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or,
3. 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,
4. 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).

For PAP devices with initial dates of service on or after January 1, 2010, physicians interpreting facility-based polysomnograms (Type I) must meet one of the requirements listed above (1-4) for credentialing.

No aspect of an HST, including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests.

## **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.

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  $\geq$  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.

If the above criteria are not met, continued coverage of a PAP device and related accessories will be denied as not medically necessary.

Beneficiaries who fail the initial 12 week trial are eligible to requalify 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).

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the patient is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

If a CPAP device is tried and found ineffective during the initial 3 month home trial, substitution of a RAD (E0470) 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 CPAP. If less than 30 days remain in the trial period, the clinical re-evaluation must occur before the 120th day following the initiation of CPAP.

If a CPAP device was used for more than 3 months and the patient was switched to a RAD, then the clinical re-evaluation would occur between the 31st and 91st day following the initiation of the RAD. There would also need to be documentation of adherence to therapy during the 3 month trial with the RAD.

If there is discontinuation of usage of a PAP device at any time, the supplier is expected to ascertain this and stop billing for the equipment and related accessories and supplies.

For a PAP device dispensed prior to November 1, 2008, if the initial Medicare coverage criteria in effect at the time were met and the criteria for coverage after the first 3 months that were in effect at the time were met, the device will continue to be covered for dates of service on or after November 1, 2008 as long as the patient continues to use the device.

# Medicare Coverage for a Respiratory Assist Device

## Overview of Coverage Criteria

A RAD (E0470, E0471) used to administer noninvasive positive pressure response assistance (NPPRA) therapy, or sometimes referred to as NPPV, is covered for those patients with clinical disorder groups characterized as restrictive thoracic disorders (ie, progressive neuromuscular diseases or severe thoracic cage abnormalities), severe chronic obstructive pulmonary disease (COPD) or central sleep apnea (CSA), and who also meet the following criteria.

For an E0470 or E0471 respiratory assist device (RAD) to be covered, the treating physician must fully document in the patient's medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.

Note: Coverage of RAD used to treat OSA has been moved to PAP Devices for Treatment of OSA LCD.

## I - Restrictive Thoracic Disorders

- A)
  - o There is documentation in the patient's medical record of a progressive neuro muscular disease (for example, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (for example, post-thoracoplasty for TB),

**and**
- B)
  - o An arterial blood gas PaCO<sub>2</sub>, done while awake and breathing the patient's usual FIO<sub>2</sub>, is  $\geq$  45mm Hg;
  - o or sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing the patient's usual FIO<sub>2</sub>;
  - o or for a progressive neuromuscular disease (only), maximal inspiratory pressure is less than 60 cm H<sub>2</sub>O or forced vital capacity is less than 50% predicted,

**and**
- C)
  - o Chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation.

If all of the above criteria are met, either RAD device (based upon the judgment of the treating physician) will be covered for patients within this group of conditions for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). If all of the above criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary.

## **II - Severe COPD**

- A)
  - o An arterial blood gas PaCO<sub>2</sub>, done while awake and breathing the patient's usual FIO<sub>2</sub>, is greater than or equal to 52 mm Hg,

**and**

  - o Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO<sub>2</sub> (whichever is higher),

**and**
- B)
  - o Prior to initiating therapy, OSA (and treatment with CPAP) has been considered and ruled out.

If all of the above criteria for patients with COPD are met, a E0470 device will be covered for the first three months of NPPRA therapy (see below for continued coverage after the initial three months). A E0471 device will not be covered for a patient with COPD during the first two months, because therapy with a E0470 device with proper adjustments of the device's settings and patient accommodation to its use will usually result in sufficient improvement without the need of a back-up rate. (See below for coverage of a E0471 device for COPD after two months' use of a E0470 device.)

If all of the above criteria are not met, E0470 and related accessories will be denied as not medically necessary. If E0471 is billed, even if the criteria for a E0470 device are met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.

For Group II patients (COPD) who qualified for a E0470 device, if at a time no sooner than 61 days after initial issue and compliant use of a E0470 device, the treating physician believes the patient requires a E0471 device, the E0471 device will be covered if the following criteria are met:

- A) 1. An arterial blood gas PaCO<sub>2</sub>, repeated no sooner than 61 days after initiation of compliant use of the E0470, done while awake and breathing the patient's usual FIO<sub>2</sub>, still remains greater than or equal to 52 mm Hg,

**and**

- B) 2. A sleep oximetry, repeated no sooner than 61 days after initiation of compliant use of a E0470 device, and while breathing with the E0470 device, demonstrates oxygen saturation less than or equal to 88% for at least five continuous minutes, done while breathing oxygen at 2 LPM or the patient's usual FIO<sub>2</sub> (whichever is higher),

**and**

- C) 3. A signed and dated statement from the treating physician, completed no sooner than 61 days after initiation of the E0470 device, declaring that the patient has been compliant using the E0470 device (an average of 4 hours per 24 hour period) but that the patient is NOT benefiting from its use,

**and**

- D) 4. A Medicare beneficiary statement completed by the patient, no sooner than 61 days after initiation of the E0470 device.

If the above criteria for a E0471 are not met, since the E0471 is in a different payment category than E0470 and a least costly medically appropriate alternative payment cannot be made, it will be denied as not medically necessary.

### **III - Central Sleep Apnea or Complex Sleep Apnea**

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

- A)
  - o The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA) (see definitions in Appendices section),

**and**

- B)
  - o The ruling out of CPAP as effective therapy if either CSA or OSA is a component of the initially observed sleep-associated hypoventilation,

**and**

- C)
  - o 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<sub>2</sub>.

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 of NPPRA therapy (see below for continued coverage after the initial three months). If all of the above criteria are not met, then E0470 or E0471 and related accessories will be denied as not medically necessary.

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 predominately 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.

## **CONTINUED COVERAGE FOR E0470 AND E0471 DEVICES BEYOND FIRST THREE MONTHS OF THERAPY**

Patients covered for the first three months of a E0470 or E0471 device must be re-evaluated to establish the medical necessity of continued coverage by Medicare beyond the first three months. While the patient may certainly need to be evaluated at earlier intervals after this therapy is initiated, the re-evaluation upon which Medicare will base a decision to continue coverage beyond this time must occur no sooner than 61 days after initiating therapy by the treating physician. Medicare will not continue coverage for the 4th and succeeding months of NPPRA therapy until this re-evaluation has been completed.

There must be documentation in the patient's medical record about the progress of relevant symptoms and patient usage of the device up to that time. Failure of the patient to be consistently using the E0470 or E0471 device for an average of four hours per 24 hour period by the time of the re-evaluation (on or after 61 days after initiation of therapy) would represent non-compliant utilization for the intended purposes and expectations of benefit of this therapy. This would constitute a reason for Medicare to deny continued coverage as not medically necessary.

The following items of documentation must be obtained by the supplier of the device for continuation of coverage beyond three months:

- A)
  - o A signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device, 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**

- B)
  - o A Medicare beneficiary statement completed by the patient no sooner than 61 days after initiating use of the device (see below).

If the above criteria are not met, continued coverage of a E0470 or E0471 device and related accessories will be denied as not medically necessary.

## **CAPPED RENTAL CHANGES**

Capped rental items are paid under the Medicare Part B durable medical equipment (DME) benefit. The final rule implements Section 5101 of the Deficit Reduction Act (DRA) requiring suppliers to transfer title of capped rental items after 13 continuous months of rental payments. This policy change, which is required by the Deficit Reduction Act of 2005 (DRA), will reduce Medicare expenditures and beneficiary coinsurance payments for the affected items of DME.

### Capped Rental Items:

Under the payment methodology in effect before the DRA, Medicare paid for certain types of DME under a capped rental arrangement, which allowed a beneficiary to either purchase the equipment after 13 continuous months or continually rent the equipment from the supplier. If the beneficiary continued to rent the equipment from the supplier, Medicare made two additional monthly payments and a semi-annual maintenance and servicing payment even if no services were furnished. Beneficiaries were responsible for a 20 percent payment equal to 20 percent of Medicare's allowed monthly rental payment amount for the equipment.

The DRA revised Medicare payments for capped rental items to 13 continuous months only. The DRA required that the supplier transfer ownership for the capped rental equipment to the beneficiary after the 13th continuous month of rental. This provision applies for capped rental items for which the first rental month occurs on or after January 1, 2006.

The DRA required that Medicare make payments for reasonable and necessary maintenance and servicing of capped rental equipment for parts and labor not covered by the supplier's or manufacturer's warranty. With the exception of capped rental items furnished prior to January 1, 2006, maintenance and servicing payments may only be made after the supplier has transferred title to the equipment to the beneficiary.

## **Diagnostic Coding**

### **ICD-9-CM Codes**

It is important to note that Medicare will not recognize all codes as medically necessary for sleep disorder testing. Medicare most commonly accepts diagnoses of sleep-related breathing disorders, narcolepsy, parasomnias and impotence.

Medicare will not cover testing when insomnia is a primary diagnosis.

In many cases the four covered diagnoses may be considered the primary diagnosis and an additional, more specific diagnosis may be included as a secondary or tertiary diagnosis.

The following listing of sleep disorders are taken directly from ICSD-2 and have been "crosswalked" to the 2006 ICD-9-CM. Please refer to page 22 for a list of the ICD-9 old codes crosswalked with the new codes.

### **Insomnia Coding**

Adjustment Insomnia	307.41
Psychophysiological Insomnia	307.42
Paradoxical Insomnia	307.42
Idiopathic Insomnia	307.42
Insomnia Due to Mental Disorder (code first mental disorder)	327.02
Inadequate Sleep Hygiene	V69.4
Behavioral Insomnia of Childhood	V69.5
Insomnia Due to Drug or Substance (Alcohol)	292.85 (291.82)
Insomnia Due to Medical Condition (code first underlying condition)	327.01
Insomnia Not Due to Substance or Known	
Insomnia, Unspecified	780.52
Organic Insomnia, Unspecified	327.00

\*Sleep testing is not covered for a primary diagnosis of Insomnia

### **Other Sleep Disorder Coding**

Physiological Sleep Disorder, Unspecified	327.8
Environmental Sleep Disorder	307.48
Fatal Familial Insomnia	046.8

## **Diagnostic Coding**

### **ICD-9-CM Codes**

#### **Sleep-Related Breathing Disorders Coding**

Primary Central Sleep Apnea	327.21
Cheyne Stokes Breathing Pattern	786.04
High-Altitude Periodic Breathing	327.22
Central Sleep Apnea in conditions classified elsewhere (code first underlying condition)	327.27
Other Organic Sleep Apnea	327.29
Primary Sleep Apnea of Infancy	770.81
Obstructive Sleep Apnea (adult) (pediatric)	327.23
Idiopathic Sleep-Related Nonobstructive Alveolar Hypoventilation	327.24
Congenital Central Alveolar Hypoventilation Syndrome	327.25
Sleep-Related Hypoventilation/Hypoxemia in conditions classifiable elsewhere (code first underlying condition)	327.26
Organic Sleep Apnea, Unspecified	327.20

#### **Hypersomnia Coding**

Narcolepsy	347.0
Narcolepsy Without Cataplexy	347.00
Narcolepsy With Cataplexy	347.01
Narcolepsy in conditions classified elsewhere (code first underlying condition)	347.1
Narcolepsy in conditions classified elsewhere Without Cataplexy	347.10
Narcolepsy in conditions classified elsewhere With Cataplexy	347.11
Kleine-Levin Syndrome	327.13
Menstrual-Related Hypersomnia	327.13
Idiopathic Hypersomnia With Long Sleep Time	327.11
Idiopathic Hypersomnia Without Long Sleep Time	327.12
Behaviorally Induced Insufficient Sleep Syndrome	307.44
Hypersomnia Due to Medical Condition (code first underlying condition)	327.14
Hypersomnia Due to Drug or Substance (Alcohol)	292.85 (291.82)
Hypersomnia due to mental disorder (code first Mental Disorder)	327.15
Organic Hypersomnia, Unspecified	327.10

# Diagnostic Coding

## ICD-9-CM Codes

### Circadian Rhythm Sleep Disorder Coding

Delayed Sleep Phase Type	327.31
Advanced Sleep Phase Type	327.32
Irregular Sleep-Wake Type	327.33
Nonentrained Type (Free Running)	327.34
Jet Lag Type	327.35
Shift Work Type	
In conditions classified elsewhere (code first underlying condition)	327.37
Other	327.39
Due to Drug or Substance (Alcohol)	292.85 (291.82)

### Parasomnia Coding

Confusional Arousals	327.41
Sleepwalking	307.46
Sleep Terrors	307.46
REM Sleep Behavior Disorder	327.42
Recurrent Isolated Sleep Paralysis	327.43
Nightmare Disorder	307.47
Dissociative Disorder or Reaction	300.15
Sleep Enuresis	788.36
Other Organic Parasomnic	327.49
Sleep Related Hallucinations	368.16
Organic Parasomnia, Unspecified	327.40
Parasomnias Due to Drug or Substance (Alcohol)	292.85 (291.82)
Parasomnias in conditions classified elsewhere (code first underlying condition)	327.44

### Sleep-Related Movement Disorder Coding

Restless Legs Syndrome	333.99
Periodic Limb Movement Disorder	327.51
Sleep Related Leg Cramps	327.52
Sleep Related Bruxism	327.53
Sleep Related Rhythmic Movement Disorder	327.59
Sleep Related Movement Disorder, Unspecified	327.59
Sleep Related Movement Disorder Due to Drug or Substance	327.59
Sleep Related Movement Disorder Due to Medical Condition	327.59

## Crosswalk Codes

Old ICD Code	Old Description	New ICD Code	ICSD Diagnosis
307.46	Sleep arousal disorder	307.46	Sleepwalking, sleep terrors
307.47	Other Dysfunction of sleep stages	307.47	Nightmares
307.48	Repetitive intrusions of sleep	307.48	Environmental sleep disorder
345.80	Other forms of epilepsy without mention of intractable epilepsy	345.80	Seizure disorder
345.81	Other forms of epilepsy with intractable epilepsy	345.81	Seizure disorder
347.00	Narcolepsy without cataplexy	347.00	Narcolepsy without cataplexy
347.01	Narcolepsy with cataplexy	347.01	Narcolepsy with cataplexy
347.10	Narcolepsy in conditions classified elsewhere, without cataplexy	347.10	Narcolepsy in conditions classified elsewhere, without cataplexy
347.11	Narcolepsy in conditions classified elsewhere, with cataplexy	347.11	Narcolepsy in conditions classified elsewhere, with cataplexy
780.51 780.53 780.57	Insomnia with sleep apnea, unspecified hypersomnia with sleep apnea, unspecified sleep apnea	327.21	Primary central sleep apnea
		327.22	High altitude periodic breathing
		327.23	Obstructive sleep apnea*
		327.24	Idiopathic sleep-related non-obstructive alveolar hypoventilation
		327.25	Congenital central alveolar hypoventilation syndrome
		327.26	Sleep-related hypoventilation/hypoxemia in conditions classified elsewhere
		327.27	Central sleep apnea due to medical condition, in conditions classified elsewhere
		327.29	Other organic sleep apnea
		786.04	Cheyne–Stokes breathing pattern
		770.81	Primary sleep apnea of infancy
780.54	Hypersomnia, unspecified	327.10-327.15	Hypersomnias
780.55	Disruption of 24 hour sleep wake cycle, unspecified	327.31-327.39	Circadian rhythm sleep disorders
780.56	Dysfunction associated with sleep stages or arousal from sleep	327.40	Organic parasomnia, unspecified
		327.41	Confusional arousals
		327.42	REM sleep behavior disorder
		300.15	Sleep related dissociative disorders
780.59	Other sleep disturbances	327.51	Periodic limb movement disorder

\* Must be used for all Medicare claims for an E0601 or E0470 device to treat OSA.

## **Procedural Coding CPT® Codes**

***Current Procedural Terminology (CPT) is copyright 2005 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.***

Medicare recognized procedural coding for sleep medicine services is found in the Current Procedural Terminology® published by the American Medical Association.

CPT is updated annually and it is essential to keep the most current copy in your office.

CPT books, along with many other useful coding resources may be purchased through the AMA at [www.amapress.com](http://www.amapress.com).

Under Medicare, the CPT coding system is used to pay claims. CPT is managed by the AMA, which has an Editorial Panel and committees to review codes and make recommendations on reimbursement.

The CPT Editorial Panel is responsible for reviewing and updating CPT by adding new codes, revising existing codes and deleting obsolete codes.

The CPT Advisory Committee assists the Editorial Panel in its work with the maintenance and interpretation of CPT. The AASM maintains one physician and one staff person as representatives on this committee.

CPT is an essential resource for your practice. Understanding the book and finding the most applicable codes can be difficult.

CPT has a table of contents located at the front of the book that tells users where each specialty's codes are located. AASM members typically use codes from the Sleep Testing family located in the Neurology and Neuromuscular Procedures subsection of the Medicine chapter.

They also routinely use codes from the Psychiatry and Health and Behavior subsets of the Medicine chapter and numerous codes from the Evaluation and Management.

# Procedural Coding

## CPT Codes

**There are three categories of CPT codes:**

### ***Category I – Traditional CPT Codes***

Services and procedures described by Category I codes have been approved by the FDA, have well established clinical efficacy, are consistent with contemporary medical practice, and are performed by many physicians.

### ***Category II – Performance Measures***

Category II codes capture performance measurement services to alleviate administrative burden on physicians by decreasing the need for record abstraction and chart review. Use of these codes is optional.

### ***Category III – Emerging Technology***

The AMA created Category III codes to facilitate data collection to substantiate widespread use of a new technology or in the FDA approval process. The codes are retired after 5 years if they have not been approved for Category I status during that time. Use of these codes is mandatory.

**Common sleep testing codes include the following:**

- |       |   |
|-------|---|
| 95805 | Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness |
| 95806 | Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist  |
| 95807 | Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, attended by a technologist  |
| 95808 | Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist  |
| 95810 | Sleep staging with four or more additional parameters of sleep, attended by a technologist  |
| 95811 | Sleep staging with four or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist       |

## **Procedural Coding CPT Codes**

### **G Codes for Home Sleep Testing:**

- G0398 Home sleep test/type II Portable Home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
- G0399 Home sleep test/type III Portable Home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
- G0400 Home sleep test/type IV Portable Home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels

### **Other common sleep medicine codes:**

- 94660 Continuous positive airway pressure ventilation (CPAP), initiation and management
- 99090 Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data)

Sleep medicine physician may often use Evaluation and Management (E&M) codes from CPT to report services. E&M coding may not be used in conjunction with code 94660 unless it is reported as a "significant, separately identifiable service" above and beyond management of the PAP therapy.

### **Common E&M codes for sleep medicine physicians include:**

- 99201 – 99215 Office or other outpatient services
- 99241 – 99245 Office or other outpatient consultations
- 99201 – 99205 Office or other outpatient services for a new patient

Selection of these codes is based on the amount of time spent with the patient and the complexity of the procedure performed.

- 99201 Requires a problem-focused history; a problem-focused examination; and straightforward medical decision making. Typically lasts 10 minutes.
- 99202 Requires an expanded problem-focused history; an expanded problem-focused examination; and straightforward medical decision making. Typically lasts 20 minutes.

## **Procedural Coding CPT Codes**

- 99203 Requires a detailed, focused history; a detailed examination; and medical decision making of low complexity. Typically lasts 30 minutes.
- 99204 Requires a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Typically lasts 45 minutes.
- 99205 Requires a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Typically lasts 60 minutes.
- 99211 –
- 99215 Office or other outpatient services for an established patient

Selection of these codes is based on the amount of time spent with the patient and the complexity of the procedure performed.

- 99211 Evaluation and management of an established patient that may not require the presence of a physician\*. Usually, the presenting problems are minimal.

\*Typically lasts five minutes.

- 99212 Requires at least two of the following three components: a problem focused history; a problem focused examination; and straightforward medical decision making. Typically lasts 10 minutes.
- 99213 Requires at least two of the following three components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Typically lasts 15 minutes.
- 99214 Requires at least two of the following three components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Typically lasts 25 minutes.
- 99215 Requires at least two of the following three components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Typically lasts 40 minutes.

99241 –

- 99245 Office or other outpatient consultations for a new or established patient

Selection of these codes is based on the amount of time spent with the patient and the complexity of the procedure performed.

- 99241 Requires a problem focused history; a problem focused examination; and straightforward medical decision making. Typically lasts 15 minutes.
- 99242 Requires an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Typically lasts 30 minutes.

## **Procedural Coding CPT Codes**

- 99243 Requires a detailed focused history; a detailed examination; and medical decision making of low complexity. Typically lasts 40 minutes.
- 99244 Requires a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Typically lasts 60 minutes.
- 99245 Requires a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Typically lasts 80 minutes.

## **Behavioral Sleep Medicine Coding**

Behavioral sleep medicine comprises the behavioral dimension of normal and abnormal sleep mechanisms and the prevention, assessment, and treatment of sleep disorders and associated behavioral, emotional, and medical problems through the application of established principles of behavior change.

Targets of intervention vary considerably and may include behavioral treatments of insomnia, medication management for narcolepsy, and CPAP desensitization protocols.

BSM therapy may be rendered by any one of a number of healthcare professionals, most commonly including physicians of numerous specialties, clinical psychologists and nurse practitioners.

There are several coding options for BSM interventions that may vary by diagnosis, setting (e.g., hospital based sleep center versus primary care), and the provider's training and area of expertise.

Physicians who provide BSM services should utilize either E&M codes listed above or a series of psychiatric codes below. These may be billed by a sleep medicine specialist with any core specialty background rather than just those with training in psychiatry. Except in situations where psychiatric diagnosis and management of a sleep disorder is performed, use of appropriate E&M coding is recommended.

## **Psychiatric Diagnosis or Evaluative Interview Procedures**

- 90801 Psychiatric diagnostic interview examination
- 90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanism

## **Procedural Coding CPT Codes**

### **Psychiatric Therapeutic Procedures Office or Other Outpatient Facility**

90804 Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;

90805 with medical evaluation and management services  
Services with medical evaluation and management involve additional work, such as diagnostic evaluation, drug management, physician orders, interpretation of lab or other studies and observations.

90806 Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;

90807 with medical evaluation and management services

90808 Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;

90809 with medical evaluation and management services

Non-physicians who provide BSM services, specifically those with training in clinical psychology are not allowed to bill either E&M or psychiatric service codes. However, a section of CPT has been established for behavioral therapy provided by these professionals. BSM services rendered by psychologists should utilize the following codes:

### **Health and Behavior Assessment/Intervention**

96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment

96151 re-assessment

## Procedural Coding CPT Codes

### Non-physician BSM Coding Continued

96152	Health and behavior intervention, each 15 minutes, face-to-face; individual
96153	group (two or more patients)
96154	family (with the patient present)
96155	family (without the patient present)

### Common sleep medicine modifiers include:

Modifier 22	<i>Unusual Procedural Service</i> This modifier is used to indicate that the procedure or service provided was greater than that usually required.
Modifier 25	<i>Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service</i> This modifier is used to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided.
Modifier 26	<i>Professional Component</i> This modifier is used for codes that are split into professional (physician) component and technical component.
Modifier TC	<i>Technical Component</i> This modifier is used for codes that are split into professional (physician) component and technical component.
Modifier 52	<i>Reduced Services</i> This modifier is used when a procedure is partially reduced or eliminated at the discretion of the physician, it is necessary to use this modifier with the procedure code.
Modifier 53	<i>Discontinued Procedure</i> This modifier is used when a physician discontinues a procedure due to extenuating circumstances or those that threaten the well being of the patient.
Modifier 59	<i>Distinct Procedural Service</i> This modifier is used when it is necessary to indicate that a procedure was distinct or independent of another procedure performed on the same date of service.

## ApneaLink™ Reimbursement

ApneaLink has been approved by the AMA for CPT code 95806, sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist, with a 52 modifier, reduced services.

As of March 13th, Medicare approved coverage of home sleep testing to qualify patients for CPAP therapy to treat OSA (NCD 240.4). Subsequently, Medicare created three new codes specific to home sleep tests:

- G0398 Home sleep test/type II portable home sleep study test (HST) with type II portable monitor, unattended; minimum of 7 channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation
- G0399 Home sleep test/type III portable home sleep test (HST) with type III portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ECG/heart rate and 1 oxygen saturation
- G0400 Home sleep test/type IV portable home sleep test (HST) with type IV portable monitor, unattended; minimum of 3 channels (ApneaLink with oximetry measures the three channels respiratory flow, pulse rate and oxygen saturation and would fall under G0400)

Further clarification regarding Type IV devices was issued in the DME MAC LCD, posted on September 18, 2008, which states that Type IV devices must monitor and record a minimum of three channels that allow direct calculation of an AHI or RDI.

Payers, including Medicare and commercial health plans, may cover CPT code 95806 and/or the G codes listed above. Please check with individual policies to verify.

ApneaLink with oximetry can also be billed under one of the following CPT codes if used for oximetry qualification:

- 94761 Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)
- 94762 Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)

It should be noted that either code requires that if a patient is being qualified for oxygen reimbursement from CMS the device must be downloaded and the data analyzed by an IDTF to qualify the patient and obtain reimbursement.

Physicians also have the discretion to bill an Evaluation and Management code for services provided in a variety of settings, including the physician office. Reimbursement levels vary on the amount of time spent with the patient in addition to other components. It is up to the physicians discretion to determine the most accurate code to report a service.

March 7, 2006

Ron Richard  
ResMed Corp.  
14040 Danielson  
Poway, Ca 92064

Dear Mr. Richard:

RE: 2714\_Unattended Sleep Airflow Evaluation

This letter is to inform you of the recent actions taken by the CPT Editorial Panel at its February 2006 meeting regarding your request for Unattended Sleep Airflow Evaluation.

Subsequent to the previous letter that was sent to you, the Panel discussed and approved coding advice related to your request at the October 2005 CPT Editorial Panel meeting. The Panel recommended that unattended sleep airflow evaluation be reported using code **95806 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist** with modifier 52, reduced services, appended.

Should you have any questions about the actions of the Panel or wish to request reconsideration by the CPT Editorial Panel Executive Committee according to the CPT process, it must be communicated in writing and received within ten business days of email notification of this memo. The request for reconsideration should include rationale and address the Panel's specific concerns. Please address your request to Marie Mindeman, Director, CPT Editorial Research and Development (312) 464-4421, fax (312) 464-5762. All requests for reconsideration through the CPT appeals process will be placed on the June 2006 agenda of the CPT Editorial Panel Executive Committee.

Respectfully,

*Marie L. Mindeman*

Marie L. Mindeman  
Director  
CPT Editorial Research and Development

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## Remote Monitoring Reimbursement

Remote monitoring devices have recently entered the sleep market. These devices facilitate accessing patient-related compliance and efficacy data. ResMed offers multiple technologies to its customers to obtain this data via ResTraxx™ System, ResScan™ Data Card and ResLink™. ResTraxx System, a wireless web-based patient monitoring solution, enables service providers to quickly identify problem patients by exception and deliver better patient care with proactive follow-up and early intervention. Patient usage and treatment efficacy data are easily downloaded from a remote monitoring device (ResTraxx Wireless), and accessed via the internet, allowing service providers to address issues as they arise and streamline the follow-up processes.

CMS granted a new remote monitoring 2007 HCPCS code:

**A9279** Monitoring feature/ device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified.

This code can be applied to numerous ResMed technologies, including: ResTraxx, ResLink and the ResScan Data Card. This code is not specific to respiratory devices and can apply to any type of monitoring system used for any type of condition.

The assigned payment category is “00” which means that Medicare will not currently be developing a fee schedule price at this time. If covered by a Medicare contractor, it would be at the discretion of the contractor.

Since there is no payment attached to the HCPCS code A9279 at this time, suppliers can consider the following options:

- o Negotiate payment with commercial healthplans
- o Bill the code, even if payment is not attached. The code will be used as a tracking tool for CMS until payment is established.

## **Letters of Medical Necessity**

Some treatments require additional justification beyond diagnosis to satisfy reimbursement requirements. In such cases, it may be necessary to submit a Letter of Medical Necessity.

The attached Letters of Medical Necessity should be used as a guide to draft a personalized letter that explains the beneficiary's medical condition and justification for the particular form of therapy. Using the supplied forms or any variation of such forms does not guarantee reimbursement. Contact the individual insurance carrier for specifics.

## Letter of Medical Necessity\*

**PATIENT NAME:**

**PHYSICIAN:**

**EQUIPMENT REQUIRED:** AutoSet Spirit™, AutoSet Respond™, AutoSet Vantage™, AutoSet II

Dear Insurance Carrier/Claim Processing Unit:

On [date] the above-named patient was diagnosed with obstructive sleep apnea (OSA), a condition in which the muscles that control the tongue and soft palate relax too much during sleep and block the upper airway, preventing breathing. The patient failed standard CPAP therapy either due to a) *positional apneic events* or b) *REM-related apneic events* that require a variable pressure range or due to c) *apneic events requiring continuous high pressures*.

A prescription for AutoSet has been ordered to rectify the patient's noncompliance with CPAP therapy. AutoSet technology monitors the state of the upper airway and adjusts pressure according to the patient's needs. It thus maintains airway stability while providing a lower overall mean pressure than does standard CPAP therapy.

This treatment provides an alternative to bilevel therapy, tracheostomy, or the less radical uvulopalatopharyngoplasty (UVPPP) surgery for this patient who was noncompliant on standard CPAP either due to intolerance or failure to prevent the regression of sleep-disordered breathing (SDB).

Thank you,

\*Claims must include documentation that the patient met all CMN criteria for OSA and tolerated the therapy prescribed.

\*Using the above form or any variation of this form does not guarantee reimbursement. Contact the individual insurance carrier for specifics.

## Letter of Medical Necessity\*

**PATIENT NAME:**

**PHYSICIAN:**

**EQUIPMENT REQUIRED:** VPAP™ III ST-A bilevel flow generator

Dear Insurance Carrier/Claim Processing Unit:

I am writing a letter of medical necessity to request authorization for PATIENT NAME to receive a bilevel respiratory assist device for the diagnosis of obstructive sleep apnea (OSA). Please note that unlike adults, the diagnosis of OSA in children is defined in the International Classification of Sleep Disorders as an apnea-hypopnea index of 1 per hour or greater (page 58). The specific device needed is a VPAP™ III ST-A. This is the only FDA device cleared for use in pediatric patients aged 7 years or older or weighing more than 40 lbs with respiratory insufficiency or OSA. This device has multiple safety features for children including a mask off alarm, power failure alarm, non-vented mask alarm, low minute ventilation alarm, and low and high pressure alarm. This request is medically necessary for the following reasons:

(PICK ALL THAT APPLY)

- 1) The patient has neuromuscular disease and requires the ventilation provided by the VPAP III ST-A.
- 2) The study shows predominantly central rather than obstructive events and Continuous Positive Airway Pressure (CPAP) was unable to treat this condition.
- 3) Patient was unable to tolerate CPAP; bilevel was better tolerated and effective in treating the sleep-disordered breathing.
- 4) The child has persistent disease despite prior surgical treatment for his/ her condition.
- 5) The child must be treated with the bilevel device because he/ she can not undergo surgery at this time due to FILL IN (for example not a surgical candidate due to other illness, unable to tolerate general anesthesia, etc.).

The prescribed device, which is HCPC code E0471, is expected to reduce if not eliminate the OSA in this child (WRITE HERE THE SPECIFIC SYMPTOMS/SIGNS THE INDIVIDUAL PATIENTS HAS).

This child prescribed device is medically necessary. OSA can be a progressive disorder. Denial of this treatment can result in significant harm to this child including cognitive and cardiovascular complications. (OPTION TO ELABORATE)

If you need any further information, please do not hesitate to call.

Thank you

## Letter of Medical Necessity\*

**PATIENT NAME:**

**PHYSICIAN:**

**EQUIPMENT REQUIRED:** VPAP™ III ST-A bilevel flow generators for central sleep apnea

Dear Insurance Carrier/Claims Processing Unit:

On [date], the above-named patient underwent an attended polysomnography (sleep study) to rule out obstructive sleep apnea as the predominant cause of their respiratory insufficiency. Multiple arousals and oxygen desaturations were demonstrated. Appropriate ventilatory support was achieved with an inspiratory pressure (IPAP) of \_\_\_\_ cm H<sub>2</sub>O and expiratory pressure (EPAP) of \_\_\_\_ cm H<sub>2</sub>O. A timed backup rate was required to effectively support the patient's respiratory efforts. The patient tolerated the procedure well.

A prescription for a VPAP III ST-A bilevel respiratory assist device (RAD) with backup rate has been recommended to support ventilatory efforts during sleep. This treatment provides an alternative to tracheostomy or the use of an invasive ventilator.

Thank you,

\*Claims should certify that the patient did not respond to other respiratory therapies and that the treatment listed above should prevent regression of the patient's disorder. Diagnosis of OSA is not required when a patient is diagnosed with respiratory or pulmonary disorders that require a respiratory assist device with a backup rate feature.

\*Using the above form or any variation of this form does not guarantee reimbursement. Contact the individual insurance carrier for specifics.

## Letter of Medical Necessity\*

**PATIENT NAME:**

**PHYSICIAN:**

**EQUIPMENT REQUIRED:** VPAP III™ ST-A bilevel flow generators for neuromuscular/restrictive disorders

Dear Insurance Carrier/Claims Processing Unit:

The above-named patient carrying the diagnosis of \_\_\_\_\_ has met the clinical criteria that support the use of a respiratory assist device (RAD) with a backup rate. (Mark all that apply.)

\_\_\_\_\_ PaCO<sub>2</sub> 45 mm Hg

\_\_\_\_\_ Oxygen desaturations 88% lasting five consecutive minutes or more

\_\_\_\_\_ Maximal inspiratory pressure (MIP) < -60 cm H<sub>2</sub>O

\_\_\_\_\_ Forced Vital Capacity (FVC) < 50% of predicted

A prescription for a VPAP III ST-A bilevel respiratory assist device (RAD) with backup rate has been recommended to support ventilatory efforts during sleep. This treatment provides an alternative to tracheostomy or the use of an invasive ventilator.

Thank you,

\*Claims must include documentation (ie, sleep report, consultation, ABG, oximetry, etc.) that the patient met the criteria and has a diagnosis of a respiratory or pulmonary disorder that requires a respiratory assist device with a backup rate.

\*Using the above form or any variation of this form does not guarantee reimbursement. Contact the individual insurance carrier for specifics.

## Letter of Medical Necessity\*

**PATIENT NAME:**

**PHYSICIAN:**

**EQUIPMENT REQUIRED:** VPAP Adapt SV™ bilevel flow generators for central sleep apnea, mixed apnea or periodic breathing

Dear Insurance Carrier/Claim Processing Unit:

On the date of \_\_\_\_\_, the above-named patient underwent an attended facility-based polysomnography (sleep study) for evaluation of suspected sleep-disordered breathing. The amount of recorded sleep time during the diagnostic portion of the study was > two hours. During the sleep study(s) the patient demonstrated:

- A) Central sleep apnea (CSA) initially or as Complex Sleep Apnea (CompSA) (see below) with:
  - 1) an apnea hypopnea index= \_\_\_/hr ( $\geq 5$ ) **and**
  - 2) central apneas/hypopneas were \_\_\_% of the total apneas/hypopneas (> 50%); **and**
  - 3) central apneas or hypopneas= \_\_\_/hr ( $\geq 5$ ) **and**
  - 4) symptoms of either excessive sleepiness or disrupted sleep were present.

Or

- B) CompSA identified by the persistence or emergence of central apneas or hypopneas with CPAP or an E0470 device when obstructive events disappeared.
  - 1) The patient had predominately (\_\_\_%) obstructive or mixed apneas/hr during the diagnostic sleep study with overall AHI at baseline= \_\_\_/hr ( $\geq 5$ ).
  - 2) With use of a CPAP or E0470, he/she showed a pattern of apneas and hypopneas with definition of CSA described above.
- C) Significant improvement of the sleep-associated hypoventilation was seen with the use of the ASV mode which automatically adjusts inspiratory pressure (IPAP) and the timed backup to effectively support the patient's respiratory efforts during central apnea/hypopnea periods.

This device has been deemed equivalent to an E0471 device for purposes of patient care and CMS reimbursement criteria by the SADMERC agency.

A prescription for a VPAP Adapt SV bilevel respiratory assist device (RAD) with backup rate has been given to the patient to support ventilatory efforts during sleep.

Thank you,

\*Claims should certify that the patient did not respond to other respiratory therapies and that the treatment listed above should prevent regression of the patient's disorder.

\* Using the above form or any variation of this form does not guarantee reimbursement. Contact the individual insurance carrier for specifics.

## Letter of Medical Necessity\*

**PATIENT NAME:**

**PHYSICIAN:**

**EQUIPMENT REQUIRED:** VPAP™ III ST-A bilevel flow generators for COPD for nocturnal hypoventilation

Dear Insurance Carrier/Claims Processing Unit:

On [date] the above-named patient underwent an attended polysomnography (sleep study) to rule out obstructive sleep apnea as the predominant cause of their respiratory insufficiency. The study primarily demonstrated nocturnal hypoventilation. Oxygen desaturations and multiple arousals from sleep persisted until appropriate ventilatory support was achieved with an inspiratory pressure (IPAP) of \_\_\_\_ cm H<sub>2</sub>O and expiratory pressure (EPAP) of \_\_\_\_cm H<sub>2</sub>O. A timed backup rate was required to effectively support the patient's respiratory efforts. The patient tolerated the procedure well.

A prescription for a VPAP III ST-A bilevel respiratory assist device (RAD) with backup rate has been recommended to support ventilatory efforts during sleep. This treatment provides an alternative to tracheostomy.

Thank you,

\*Claims must include documentation (ie, sleep report, consultation, ABG, oximetry, etc.)that the patient met the criteria and has a diagnosis of a respiratory or pulmonary disorder that requires a respiratory assist device with a backup rate.

\*Using the above form or any variation of this form does not guarantee reimbursement. Contact the individual insurance carrier for specifics.

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