

RESMED

2010

**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.

2010 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	No Current Fee Schedule	
A9999	NU	Misc. DME supply or accessory not otherwise specified.	Contractor Priced	Contractor Priced
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

RR = RENTAL EQUIPMENT

NU = NEW EQUIPMENT

UE = USED EQUIPMENT

Recommended Replacement Schedule Allowable for Accessories

This section discusses Medicare 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.

Code	Accessory Description	Recommended Replacement Schedule
A4604	Tubing with integrated heating	1 per 3 months
A7027	Combination oral/nasal mask	1 per 3 months
A7028	Oral cushion for combination oral/nasal mask - Replacement	2 per 1 month
A7029	Nasal pillows for combination oral/nasal mask - Replacement	2 per 1 month
A7030	Full face mask	1 per 3 months
A7031	Face mask interface replacement, each	1 per 1 month
A7032	Replacement nasal cushion	2 per 1 month
A7033	Replacement pillows	2 pair per 1 month
A7034	Nasal interface (mask or cannula type) used with PAP device	1 per 3 months
A7035	Headgear, used with PAP device	1 per 6 months
A7036	Chin strap, used with PAP	1 per 6 months
A7037	Tubing, used with PAP device	1 per 3 months
A7038	Filter, disposable, used with PAP	2 per 1 month
A7039	Filter, non-disposable, used with PAP	1 per 6 months
A7046	Humidifier chamber replacement, each	1 per 6 months
A9279	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
ClimateLine Tubing	36995	A4604
ConvertAble Pack Mirage SoftGel / Mirage Activa LT	61609, 61615	A7034 + A7035 + A7032
HumidAire 2i	30902	E0562
HumidAire 2iC Passive Humidifier	30927	E0561
HumidAire 3i	33906	E0562
H4i Heated Humidifier	26940	E0562
H4i Heated Humidifier Water Chamber	26952	A7046
H4i Heated Humidifier Conversion Kit	26959	A7046
H5i Heated Humidifier	36900	E0562
H5i Heated Humidifier Water Tub	36802	A7046
Meridian Nasal Mask	61102, 61103	A7034 + A7035
Meridian Headgear	61117	A7035
Mirage Activa Cushions	60117, 60118, 60119	A7032
Mirage Activa Headgear	16118, 16119, 60114	A7035
Mirage Activa Nasal Mask	60100, 60101, 60102	A7034 + A7035
Mirage Activa LT Nasal Mask	60148, 60149, 60150, 60182	A7034 + A7035
Mirage Activa LT Nasal Mask Frame	60195, 60172, 60173, 60174	A7034
Mirage Activa LT Nasal Cushion	60177, 60178, 60179, 60198	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

ResMed Products and Applicable HCPCS Codes

PRODUCT NAME	RESMED PART #(S)	HCPCS CODE
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
Mirage SoftGel Nasal Cushion	61632, 61633	A7032
Mirage SoftGel Nasal Mask	61601, 61602	A7034 + A7035
Mirage SoftGel Nasal Mask Frame System	61627, 61628	A7034
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) 30924 + 22212 + 30942 (S7)	A9279
ResScan	22903+22207+31301	A9279
ResTraxx	22204, 30905	A9279
ResTraxx GSM	22230	A9279

ResMed Products and Applicable HCPCS Codes

PRODUCT NAME	RESMED PART #(S)	HCPCS CODE
S7 Elite	30002	E0601
S7 Lightweight	30011	E0601
S8 AutoSet Vantage	33112	E0601 + A9279
S8 Compact	33030	E0601
S8 AutoSet II	33129	E0601 + A9279
S8 AutoSet II and H4i	33150	E0601 + A9279 + E0562
S8 Elite	33021	E0601 + A9279
S8 Elite II	33039	E0601 + A9279
S8 Elite II and H4i	33062	E0601 + A9279 + E0562
S8 Escape	33007	E0601 + A9279
S8 Escape and H4i	33060	E0601 + A9279 + E0562
S8 Escape II	33051	E0601 + A9279
S8 Escape II Auto	33064	E0601 + A9279
S8 Escape II and H4i	33061	E0601 + A9279 + E0562
S8 Escape II Auto with H4i	33077	E0601 + A9279 + E0562
S9 AutoSet	36005	E0601 + A9279
S9 AutoSet with H5i	36015	E0601 + A9279 + E0562
S9 Elite	36003	E0601 + A9279
S9 Elite with H5i	36013	E0601 + A9279 + E0562
Swift FX Nasal Pillows System	61500	A7034 + A7035
Swift FX Nasal Frame	61510, 61511, 61512, 61513	A7034
Swift FX Nasal Pillows	61520, 61521, 61522, 61523	A7033
Swift LT Nasal Pillows System	60560	A7034 + A7035
Swift LT Headgear	60578	A7035
Swift LT / Swift LT for Her Nasal Pillows	60571, 60572, 60573, 60574	A7033

ResMed Products and Applicable HCPCS Codes

PRODUCT NAME	RESMED PART #(S)	HCPCS CODE
Swift LT for Her Nasal Pillows System	60588	A7034 + A7035
Swift LT for Her Headgear	60595	A7035
Ultra Mirage Full Face Mask	60600, 60601, 60602, 60603, 60604, 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 III ST-A	24116	E0471
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 Malibu	26201	E0470

Medicare Coverage for PAP Devices for the Treatment of OSA

Policy revised January 1, 2010

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 (ie, must reach ≥ 30 events without symptoms or ≥ 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.

A home sleep test (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 allows calculation of an AHI or RDI as the result of measuring airflow or thoracoabdominal movement.

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 coverage based on a facility-based polysomnogram (Type 1) performed on or after January 1, 2010, the interpreting physician 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 (RAD)

Policy revised February 1, 2010

Overview of Coverage Criteria

A RAD (E0470, E0471) is covered for those patients with clinical disorder groups characterized as (I) restrictive thoracic disorders (ie, neuromuscular diseases or severe thoracic cage abnormalities), (II) severe chronic obstructive pulmonary disease (COPD), (III) central sleep apnea (CSA) or complex sleep apnea (CompSA), or (IV) hypoventilation syndrome.

I. Restrictive Thoracic Disorders

An E0470 or E0471 device is covered when criteria A – C are met.

- A. There is documentation in the patient's medical record of a neuromuscular disease (eg, amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (eg, post-thoracoplasty for TB).
- B. One of the following:
 - a. An arterial blood gas PaCO₂, done while awake and breathing the patient's prescribed FiO₂, is ≥ 45 mm Hg, or
 - b. Sleep oximetry demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing the patient's prescribed recommended FiO₂, or
 - c. For a neuromuscular disease (only), either i or ii:
 - i. Maximal inspiratory pressure is <60 cm H₂O or
 - ii. Forced vital capacity is $< 50\%$ predicted.
- C. Chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation.

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

II. Severe COPD

An E0470 device is covered if criteria A - C are met.

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

If all of the above criteria for patients with COPD 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 in either of the two situations below, depending on the testing performed to demonstrate the need.

Situation 1. For Group II patients (COPD) who qualified for an E0470 device, an E0471 started any time after a period of initial use of an E0470 device is covered if both criteria A and B are met:

- A. An arterial blood gas PaCO₂, done while awake and breathing the patient's prescribed FiO₂, shows that the beneficiary's PaCO₂ worsens ≥ 7 mm Hg compared to the original result from criterion A (above); and
- B. A facility-based PSG demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours) while using an E0470 device that is not caused by obstructive upper airway events – ie, AHI < 5 . (Refer to the Positive Airway Pressure Devices LCD for information about E0470 coverage for obstructive sleep apnea)

Situation 2. For Group II patients (COPD) who qualified for an E0470 device, an E0471 device will be covered if, at a time no sooner than 61 days after initial issue of the E0470 device, both of the following criteria A and B are met:

- A. An arterial blood gas PaCO₂, is done while awake and breathing the patient's prescribed FiO₂, still remains ≥ 52 mm Hg; and
- B. Sleep oximetry while breathing with the E0470 device demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2 LPM or the patient's prescribed FiO₂ (whichever is higher).

III. Central Sleep Apnea or Complex Sleep Apnea

An E0470 or E0471 device is covered when, prior to initiating therapy, a complete facility-based, attended PSG is performed documenting the following:

- A. The diagnosis of central sleep apnea (CSA) 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 prescribed FiO₂.

If all of the above criteria are met, either an E0470 or an 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 therapy.

IV. Hypoventilation Syndrome

An E0470 device is covered if criteria A, B, and either C or D are met:

- A. An initial arterial blood gas PaCO₂, done while awake and breathing the patient's prescribed FiO₂, is ≥ 45 mm Hg.
- B. Spirometry shows an FEV1/FVC $\geq 70\%$ and an FEV1 $\geq 50\%$ of predicted. (Refer to II. Severe COPD (above) for information about device coverage for patients with FEV1/FVC $< 70\%$ or FEV1 $< 50\%$ of predicted).
- C. An arterial blood gas PaCO₂, done during sleep or immediately upon awakening and breathing the patient's prescribed FiO₂, shows the beneficiary's PaCO₂ worsened ≥ 7 mm Hg compared to the original result in criterion 1 (above).

- D. A facility-based PSG demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events – ie, $AHI < 5$. (Refer to the Positive Airway Pressure Devices LCD for information about E0470 coverage for obstructive sleep apnea).

If the above criteria are not met, E0470 and related accessories will be denied as not medically necessary.

An E0471 device is covered for a patient with hypoventilation syndrome if criteria A, B, and either C or D are met:

- A. A covered E0470 device is being used.
- B. Spirometry shows an $FEV1/FVC \geq 70\%$ and an $FEV1 \geq 50\%$ of predicted. (Refer to II. Severe COPD (above) for information about device coverage for patients with $FEV1/FVC < 70\%$ or $FEV1 < 50\%$ of predicted).
- C. An arterial blood gas $PaCO_2$, done while awake and breathing the patient's prescribed FiO_2 , shows that the beneficiary's $PaCO_2$ worsens ≥ 7 mm Hg compared to the ABG result performed to qualify the patient for the E0470 device.
- D. A facility-based PSG demonstrates oxygen saturation $\leq 88\%$ for ≥ 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events (ie, $AHI < 5$) while using an E0470 device. (Refer to the Positive Airway Pressure Devices LCD for information about E0470 coverage for obstructive sleep apnea.)

CONTINUED COVERAGE CRITERIA FOR E0470 AND E0471 DEVICES BEYOND THE FIRST THREE MONTHS OF THERAPY:

Patients covered for the first three months of an E0470 or an E0471 device must be re-evaluated to establish the medical necessity of continued coverage by Medicare beyond the first three months. 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.

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.

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 compliantly using the device (an average of 4 hours per 24-hour period) and that the patient is benefiting from its use, must be obtained by the supplier of the device for continued coverage beyond three months. If the above criteria are not met, continued coverage of an E0470 or an 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 2009 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.

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.
- 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.

Procedural Coding CPT Codes

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

- 99211 – 99215 Office or other outpatient services for an established patient
- 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.
- 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.

Procedural Coding CPT Codes

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 (eg, 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

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:

Procedural Coding CPT 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

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 *Unusual Procedural Service*
This modifier is used to indicate that the procedure or service provided was greater than that usually required.
- Modifier 25 *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service*
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 *Professional Component*
This modifier is used for codes that are split into professional (physician) component and technical component.
- Modifier TC *Technical Component*
This modifier is used for codes that are split into professional (physician) component and technical component.
- Modifier 52 *Reduced Services*
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 *Discontinued Procedure*
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 *Distinct Procedural Service*
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™/ApneaLink Plus are home sleep test screening and diagnostic devices. ApneaLink/ApneaLink Plus can be used as part of a comprehensive protocol to screen and/or diagnose patients with obstructive sleep apnea (OSA), central apneas and mixed apneas, as well as identify patients with Cheyne-Stokes respiration (CSR). Payor coverage of home sleep tests may vary. Therefore there are a variety of ways ApneaLink, ApneaLink with oximetry and ApneaLink Plus with oximetry can be billed.

Screening

ApneaLink can be used as a screening device to identify patients with OSA for referrals to in-lab diagnostic testing. There is not a separate and distinct code for screening. Physicians have the discretion to bill an Evaluation and Management code for services provided in a variety of settings, including the physician office. If physicians spend additional time with a patient reviewing screening options or results from a screening test, it is up to the physician's discretion to determine if a higher level Evaluation and Management code is applicable.

Type IV Home Sleep Test

ApneaLink with oximetry can be used with certain payors as a three-channel home sleep test device. Payors, including Medicare and commercial health plans, may cover CPT code 95806 and/or the G codes listed below. Please check with individual policies to verify.

HCPCS code G0400

Description: Home sleep test/Type IV portable home sleep test (HST) with Type IV portable monitor, unattended; minimum of 3 channels

CPT code 95806-52

Description: Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist, with a reduced services modifier.

Type III Home Sleep Test

ApneaLink Plus with oximetry can be used with certain payors as a Type III, four-channel home sleep test device. Please check with individual policies to verify.

HCPCS code G0399

Description: Home sleep test/Type III portable home sleep test (HST) with Type III portable monitor, unattended; minimum of four channels: two respiratory movement/airflow, one ECG/heart rate and one oxygen saturation.

CPT code 95806

Description: Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist

Remote Monitoring Reimbursement

Remote monitoring devices facilitate accessing patient-related compliance and efficacy data. ResMed offers multiple technologies to its customers to obtain this data via the ResTraxx™ System, ResScan™ Data Card, the S9 SD 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 and S9 SD Data Cards. 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.

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