Billing Criteria
Medicare has specific criteria for coverage of CPAP and bilevel devices for treatment of OSA. Please refer to the local coverage policy for additional details. ¹

<table>
<thead>
<tr>
<th>Device</th>
<th>Description</th>
<th>HCPCS</th>
<th>2015 Medicare Reimbursement¹ (Competitive bid rates will vary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPAP</td>
<td>CPAP devices (e.g., AirSense™ 10). Includes automatic positive airway pressure (APAP) devices (e.g., AirSense 10 AutoSet®)</td>
<td>E0601</td>
<td>$106.87 – 90.84² (monthly rate)</td>
</tr>
<tr>
<td>Bilevel</td>
<td>Bilevel devices without a backup rate (e.g., AirCurve™ 10 VAuto, AirCurve 10 S, VPAP COPD)</td>
<td>E0470</td>
<td>$245.48 – 208.66² (monthly rate)</td>
</tr>
</tbody>
</table>

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Key Coverage Criteria Required for All CPAP Claims
A single-level CPAP device (E0601) is covered for the treatment of OSA if criteria A-C are met:
A. The patient has face-to-face clinical evaluation by treating physician prior to the sleep test to assess the patient for OSA. NOTE: Physicians shall document the face-to-face evaluation and re-evaluation in a detailed narrative note in their charts. For the initial evaluation, the report would commonly document pertinent information (i.e., history and physical exam), but may include other details.
B. The patient has a sleep test that meets either of the following criteria:
   1. The apnea–hypopnea index (AHI) or respiratory disturbance index (RDI)* is ≥ 15 events per hour with minimum of 30 events;
   2. The AHI or RDI is ≥ 5 and ≤ 14 events per hour with minimum of 10 events and documentation of:
      a. Excessive daytime sleepiness, impaired cognition, mood disorders or insomnia;
      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.

Key Coverage Criteria for Sleep Tests
- Covered sleep tests include Type I, II, III or IV devices
- Beneficiaries must receive face-to-face demonstration, or video or telephonic instruction on HST device prior to test
- Education on HST device must be provided by entity performing the test (not by DME supplier)
- All sleep tests must be interpreted by a physician who holds either:
  1. Current certification in sleep medicine by the American Board of Sleep Medicine (ABSM);
  2. Current subspecialty certification in sleep medicine by member board of American Board of Medical Specialists (ABMS).
3. Completed training by ABMS member board and completed all requirements for subspecialty certification in sleep except exam itself; or
4. Active staff of a sleep center or lab accredited by the AASM, ACHC or The Joint Commission.

**Continued Coverage Beyond the First Three Months of Therapy**
Continued coverage documented between 31st and 91st day after initiation of therapy

1. Face-to-face clinical re-evaluation by treating physician and documentation of improved symptoms of OSA; and
2. Physician review of objective evidence of adherence (defined as use of PAP ≥4 hours per night on 70% of nights during a consecutive 30-day period) via AirView, direct download or visual inspection of usage data.

**Continued Coverage Documentation for Bilevel Devices:**
Switch to bilevel day 1–60 following CPAP setup
Obtain Rx for E0470 device (clinical re-evaluation must occur between 31st and 91st day following initiation of CPAP)

Switch to bilevel day 61–90 following CPAP setup
Obtain Rx for E0470 device (clinical re-evaluation must occur before 120th day following initiation of CPAP)

Switch to bilevel post day 90 following CPAP setup
Obtain Rx for E0470 device and new initial face-to-face clinical evaluation (clinical re-evaluation must occur between 31st and 91st day following initiation of bilevel)

**Q & A**

**Q: What if a patient fails the initial trial?**
A patient is eligible to requalify if they have another face-to-face clinical evaluation by the treating physician and a repeat sleep test in a facility-based setting (Type I study).

**Q: Does the treating physician who completes the initial face-to-face exam have to write the order for the PAP therapy?**
No, the treating physician who does the initial face-to-face exam does not have to be the same physician who orders the PAP. For example, the PAP device can be ordered by a physician from the sleep lab.

**Q: If a patient was diagnosed with OSA and received a PAP device paid for by private insurance, and the patient is now enrolled in Fee-For-Service (FFS) Medicare and needs a replacement device, what is required for coverage?**
Prior to FFS Medicare enrollment, the patient must have a sleep test that meets the FFS Medicare AHI coverage criteria in effect at the time that the beneficiary seeks a replacement PAP device and/or accessories. Following enrollment, the patient must also have a face-to-face evaluation by their treating physician that documents a diagnosis of OSA and that the patient continues to use the PAP device. In these situations, there is no requirement for a clinical re-evaluation or for objective documentation of adherence to use of the device.

**Q: Can results from a sleep study be used to qualify patients for home oxygen?**
Coverage of home oxygen therapy requires that the patient be tested in the “chronic stable state.” For patients with OSA to be considered in the chronic, stable state, OSA must be sufficiently treated such that the underlying severe lung disease is unmasked. Please see Medicare’s FAQ on Oxygen use in beneficiaries with OSA.

**Q: What does a Medicare prescription need to include to authorize delivery of a DME item?**
A detailed written order (DWO) is required before billing. The DWO must contain: 1) the beneficiary’s name; 2) the prescribing practitioner’s NPI; 3) the order’s start date; 4) a detailed description of the item(s) (see below for specific requirements for selected items); and 5) the physician’s name, physician signature and signature date.

For items provided on a periodic basis, like CPAP supplies and accessories, the written order must include: Item(s) to be dispensed, frequency of use, quantity to be dispensed, duration of need and number of refills. The detailed description in the written order may be either a narrative description (e.g., pillows mask) or a brand name/model number.

For items listed in MLN Matters® Number: MM32004, such as E0470, E0471, and E0601, documentation that a physician has had a face-to-face encounter examination with a beneficiary in the six (6) months prior to the written order is required.

1 The rates listed are based on the Medicare 2015 DMEPOS National Fee Schedule. Competitive bidding rates may be applicable in certain CBAs; please reference the single payment amounts for these areas.
2 2015 Medicare ceiling and floor rates; rate reduces by 25% after the third month; payment over 13 months. Actual allowables vary by state.
3 Centers for Medicare & Medicaid Services, “PAP Devices for the Treatment of OSA” (L1152B, L2723O, L11518, L1711), U.S. Department of Health and Human Services (revision effective date 10/31/2014)
4 FAQ: Oxygen Use in Beneficiaries with Obstructive Sleep Apnea, 11/22/13
5 MLN Matters Number: MM32004, 7/1/13