POSITIVE AIRWAY PRESSURE DEVICES: INITIAL QUALIFICATION

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Dear Clinician,

For Medicare to provide reimbursement for positive airway pressure (PAP) devices used to treat obstructive sleep apnea (OSA), the medical necessity documentation requirements for the coverage criteria must be met. The following information is intended to provide you with summary guidance on Medicare's coverage criteria and documentation requirements for PAP devices.

A separate "Dear Physician" letter addresses the documentation necessary for your patient to receive a replacement PAP device or ongoing supplies.

Initial Qualification

For your patient diagnosed with OSA for the first time after becoming Medicare-eligible, the coverage criteria and documentation requirements for initial qualification of a PAP device for OSA are:

- A clinical evaluation: an in-person or Medicare-approved telehealth evaluation with your patient, prior to the sleep test. This should generally include the following elements:
  - Sleep history and symptoms which may be caused by OSA;
  - Pertinent physical examination, such as body mass index, neck circumference, upper airway exam, and focused cardiopulmonary exam;
  - Epworth Sleepiness Scale (a standardized patient questionnaire which helps to assess the likelihood of sleep apnea), or other validated sleep inventory. (The Epworth Sleepiness Scale may be located in the Appendices section of the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea Local Coverage Determination [LCD].)
- A polysomnogram performed in a facility-based laboratory (Type I study) or, an inpatient hospital-based or home-based sleep test (HST) (Types II, III, IV, Other). The sleep test results must meet 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.

  (Note: Coverage and Payment rules for diagnostic sleep tests may be found in the CMS National Coverage Determination [NCD] 240.4.1 [CMS Pub. 100-03, Chapter 1, Part 4], the applicable A/B MAC LCDs and Billing and Coding articles.]

- A standard written order (SWO) for the PAP device and any related accessories and/or supplies.
- Documentation from the supplier that the beneficiary, and/or their caregiver, has received instruction from the supplier of the device in the proper use and care of the equipment.

Continued Coverage

Continued coverage of the PAP device beyond the initial three (3) month trial requires that, no sooner than the thirty-first (31st) day but no later than the ninetieth (90th) day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy. This may be demonstrated by:

1. A clinical re-evaluation: an in-person or Medicare-approved telehealth visit with your patient during the second or third month of the trial (but not before that time) that documents an improvement in their sleep-disordered breathing symptoms; and,

2. Review of objective evidence of adherence to use of the PAP device, reviewed by you, that documents use of the PAP device for at least four (4) hours per night on seventy percent (70%) of nights for a thirty (30) consecutive day period during the trial (i.e., twenty-one [21] nights in a thirty [30] consecutive day period).

It is critical to stay in communication with your patient's DME supplier or track compliance yourself so that once your patient meets the thirty (30) day adherence metric, a follow-up visit can be scheduled within the thirty-first (31st) to ninetieth (90th) day window.

This summary is not intended to take the place of the written law, regulations, national coverage determinations (NCDs) or LCDs. Coverage, coding and documentation requirements may be found in the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea LCD (L33718) and LCD-related Policy Article (A52467), located on the Medicare Coverage Database.

Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers are your partners in caring for your patient. They will not receive payment from Medicare for the items that are ordered for your patient if you do not provide information from the patient's medical record to the supplier when it is requested. Furthermore, if you do not provide the requested information to the supplier, your patient may have to pay for the item. Finally, your

cooperation is a legal requirement as outlined in the Social Security Act which is the law governing Medicare. Help your DMEPOS supplier continue to provide the highest quality of service to your patient by promptly providing them with the requested information.

Your participation and cooperation with the supplier in this process will allow your patient to receive the most appropriate type of equipment. We appreciate all your efforts in providing quality services to your Medicare patients.

Sincerely,

Noridian Healthcare Solutions Medical Directors	CGS Administrators Medical Directors
Smitha M. Ballyamanda, MD, CAQSM Medical Director, DME MAC, Jurisdiction A Noridian Healthcare Solutions, LLC	Sunil V. Lalla, MD, FACS, CPC Medical Director, DME MAC, Jurisdiction B CGS Administrators, LLC
Angela S. Jenny, DO Medical Director, DME MAC, Jurisdiction D Noridian Healthcare Solutions, LLC	Robert D. Hoover, Jr., MD, MPH, FACP Medical Director, DME MAC, Jurisdiction C CGS Administrators, LLC