



What's needed for a new referral:

- Demographics
- Detailed Written Order Signed/Dated by physician
- Most recent Face-To-Face note discussing the item the patient is needing as well as the diagnosis

**Policy References:** Local Coverage Determination Positive Airway Pressure (PAP) Devices (L33718) and Policy Article (A52467)

**Documentation References:** Standard Documentation Requirements Policy Article (PA) A55426

**The supplier must be able to provide all of these items on request:**

- ☐ Standard Written Order (SWO)
- ☐ Refill Requirements
- ☐ Beneficiary Authorization
- ☐ Proof of Delivery (POD)
- ☐ Continued Need
- ☐ Continued Use
- ☐ Medical records from treating practitioner as noted below

**Medical Records should contain:**

Initial coverage (First 3 months)

Positive Airway Pressure Device - E0601

CPAP

- ☐ Face to Face (F2F) prior to the sleep test to assess the beneficiary for obstructive sleep apnea (OSA); **and**
- ☐ Medicare-covered sleep test that meets either:
  - ☐ Apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI)  $\geq 15$  events per hour with a minimum of 30 events; **or**
  - ☐ AHI or RDI  $\geq 5$  and  $\leq 14$  events per hour with minimum 10 events and documentation of:
    - ☐ Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; **or**
    - ☐ Hypertension, ischemic heart disease, or history of stroke, **and**
- ☐ Documentation the beneficiary and/or their caregiver has received instruction from the supplier of the PAP device in the proper use and care of the equipment.

Documentation for Beneficiaries Who Fail the Initial 12 Week Trial

- ☐ F2F re-evaluation to determine the etiology of the failure to respond to PAP therapy; **and**

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- ☐ Repeat sleep test in a facility-based setting (Type 1 study).

Bi-level Respiratory Assist Device (RAD) without Back-up Rate (E0470)

- ☐ Beneficiary meets all the criteria listed above for a positive airway pressure device (E0601); **and**
- ☐ An E0601 PAP device has been tried and proven ineffective based on a therapeutic trial conducted in either a facility or home setting.
  - ☐ Documented failure to meet therapeutic goals using an E0601 during the titration portion of a facility-based study or during home use despite optimal therapy
  - ☐ A new initial F2F if E0601 has been used for more than 3 months and the beneficiary switched to E0470 (a new sleep test is not required)

PAP – Continued Coverage (Beyond the First 3 Months of Therapy)

- ☐ Documentation the beneficiary is benefiting from PAP therapy as demonstrated by:
- ☐ F2F re-evaluation by the treating physician between the 31st and 91st day after initiating therapy documenting that symptoms of OSA are improved; **and**
- ☐ Objective evidence of adherence to use of the PAP device reviewed by treating physician.
  - ☐ Adherence is defined as use of the PAP device  $\geq 4$  hours per night on 70% of nights during a consecutive 30 day period anytime during the first 3 months of initial use

Beneficiaries Entering Medicare

- ☐ Sleep test – Documentation the beneficiary had a sleep test, prior to FFS Medicare enrollment, that meets Medicare AHI/RDI coverage criteria in effect at the time the beneficiary seeks replacement PAP device and/or accessories; **and**
- ☐ Clinical Evaluation – Following enrollment in FFS Medicare, the beneficiary must have a F2F which documents:
  - ☐ Diagnosis of OSA; **and**
  - ☐ The beneficiary continues to use the PAP device.

Replacement (E0601, E0470)

- ☐ Replacement following the 5 year reasonable useful life (RUL) requires a F2F that documents the beneficiary continues to use and benefit from the PAP device

Non-Heated or Heated Humidifier (E0561, E0562)

- ☐ Beneficiary meets PAP coverage criteria; **and**
- ☐ Standard written order includes the type of humidification



DETAILED PHYSICIANS ORDER  
RESPIRATORY EQUIPMENT

Patient: \_\_\_\_\_ Date of Order: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Length of Need: 99

Diagnosis Codes: \_\_\_\_\_

Equipment Needed:

- |  |   |
|--|---|
| <input type="checkbox"/> E0570 – Nebulizer with compression                        | <input type="checkbox"/> E0601- CPAP settings: _____                |
| <input type="checkbox"/> Nebulizer Admin Sets                                      | <input type="checkbox"/> E0470- BiPAP settings: _____               |
| <input type="checkbox"/> A7003 – Admin sets (2/month)                              | <input type="checkbox"/> E0471 BiPAP ASV settings: _____            |
| <input type="checkbox"/> A7015 – Aerosol Mask (1/month)                            | <input type="checkbox"/> E0562 Heated Humidifier                    |
| <input type="checkbox"/> E0463- Volume Control Ventilator Invasive Interface       | <input type="checkbox"/> CPAP/BiPAP/Respiratory assist Supplies:    |
| <input type="checkbox"/> E0464 – Volume Control Ventilator Non- Invasive Interface | <input type="checkbox"/> A7030 – Full Face Mask (1/3mo)             |
| <input type="checkbox"/> E0482 – Cough Stimulating Device                          | <input type="checkbox"/> A7031 – Face mask interface (1/1mo)        |
| <input type="checkbox"/> E0439 – Stationary Liquid Oxygen System                   | <input type="checkbox"/> A7032 – Nasal cushions (2/1mo)             |
| <input type="checkbox"/> E0463 – Volume Control Ventilator                         | <input type="checkbox"/> A7033 – Nasal pillows (2/1mo)              |
| <input type="checkbox"/> Invasive Interface  | <input type="checkbox"/> A7034 – Nasal application device (1/3mo)   |
| <input type="checkbox"/> E0464 – Volume Control Ventilator                         | <input type="checkbox"/> A7035 – Headgear (1/6mo)                   |
| <input type="checkbox"/> Non-invasive Interface                                    | <input type="checkbox"/> A7036 – Chinstrap (1/6mo)                  |
| <input type="checkbox"/> E0482 – Cough Stimulating Device                          | <input type="checkbox"/> A7037 – PAP tubing (1/3mo)                 |
| <input type="checkbox"/> E0439- Stationary Liquid Oxygen System                    | <input type="checkbox"/> A7038- PAP filter disposable (2/1mo)       |
| <input type="checkbox"/> E0443 – Oxygen contents-gas                               | <input type="checkbox"/> A7039- PAP filter non-disposable (1/6mo)   |
| <input type="checkbox"/> E0434 – Portable Liquid Oxygen system                     | <input type="checkbox"/> A7044- PAP oral interface (1/6mo)          |
| <input type="checkbox"/> E0431 - Gaseous Oxygen Regulator                          | <input type="checkbox"/> A7046- Replacement water chamber (1/6mo)   |
| <input type="checkbox"/> E1392 – Portable oxygen concentrator                      | <input type="checkbox"/> A4604- Tubing with heating element (1/3mo) |
| <input type="checkbox"/> E1390 - Oxygen Concentrator                               |   |

Oxygen LPM \_\_\_\_\_ Continuous/With Exercise/Nocturnal  
Via Nasal Cannula \_\_\_\_\_ OR Mask \_\_\_\_\_ OR Bled into PAP Device \_\_\_\_\_  
OR Invasive Vent \_\_\_\_\_

☐ TEST ON CONSERVER

Titrate patient's oxygen setting to achieve an SpO<sub>2</sub> ≥ 90%  
at rest and during activities of daily living via pulse  
oximetry; and set up on the appropriate conserving  
device or portable oxygen concentrator.

☐ Overnight Pulse Oximetry On:  
ROOM AIR \_\_\_\_\_  
Oxygen \_\_\_\_\_ @ \_\_\_\_\_ lpm.  
CPAP \_\_\_\_\_  
BiPAP \_\_\_\_\_

☐ Other Please Specify:  
\_\_\_\_\_  
\_\_\_\_\_

Physicians

Name: \_\_\_\_\_

Physicians

Signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

NPI: \_\_\_\_\_

Fax: \_\_\_\_\_

Showroom location for new patients and walk-ins:  
1005 N Kingshighway Ste 12 Cape Girardeau ph. 573-803-2390 fax 573-803-1247