

FAQs for Positive Airway Pressure Devices

Accompaniment to DME LCD Policy for CPAP Therapy

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1. Who is responsible for ensuring that the initial clinical evaluation and re-evaluation were conducted and who must retain documentation of that evaluation? Answer: The treating physician is responsible for documenting the elements of the clinical evaluation and re-evaluation and must maintain that documentation as they would with any patient. Suppliers are responsible for ensuring that the coverage criteria have been met before applying the KX modifier to the code for PAP devices and accessories. Suppliers have the option of either requesting the information from the physician prior to dispensing the PAP device or waiting until requested to submit the information to the DME MAC.

2. Will phone-in compliance satisfy the requirement for demonstrating that the patient must be compliant with therapy for 4 or more hours a night for 70% of the nights in a consecutive 30-day period within the first 90 days of therapy? Answer: Yes, this is acceptable. The policy allows for either direct download or visual inspection of adherence information.

3. Does the equipment provided to the patient during the initial 90-day therapy trial period have to be new? Answer: No, it does not have to be new but must be in good working condition.

4. Is ICD-9 diagnosis code 327.23 the only code acceptable for PAP device claims and when does its use become mandatory? Answer: Yes, ICD-9 code 327.23 is the only code acceptable for PAP and is the code that should have been used on claims since becoming effective in January 2006. Prior to the creation of code 327.23, other ICD-9 codes were allowed because there was no ICD-9 code specific to obstructive sleep apnea. Suppliers should always use the ICD-9 code that accurately and specifically reflects the condition for which the equipment is covered. ICD-9 code 327.23 should be used on all claims at this time for patients with obstructive sleep apnea.

5. Does a new order need to be obtained reflecting diagnosis code 327.23 for beneficiaries already in the capped rental cycle? Answer: No, as long as the supplier of the PAP device has information from the treating physician that the patient has obstructive sleep apnea.

6. What happens if a RAD device is put on a patient at a point in time where it is now impossible to meet the compliance requirement for 70% of the nights in a consecutive 30-day period within that first 90 days? Say for example, the patient changes over from a CPAP to a RAD device on day 75? Answer: Patients will be given until the 120th day after initiation of CPAP to document adherence to therapy.

7a. What happens if all of the documentation needed to continue therapy beyond the first 90 days is not received/available to the supplier before the end of the 90 day trial period but does become available later - possibly at 120 or 150 days, for example?

Answer: The supplier has two options:

- Submit the claims without the KX modifier; or,
- Hold claims until the proper documentation has been received. If the documentation confirms that the beneficiary was adherent to therapy and had a face-to-face re-evaluation between the 31st and 91st day, the claims being held may be submitted with the KX modifier.

7b. What if the beneficiary *did not* have the required re-evaluation within the 31st to 91st day window?

Answer: If the documentation shows that the beneficiary was adherent to therapy and demonstrated improvement in symptoms but *did not* have a face-to-face re-evaluation between the 31st and 91st day but rather was re-evaluated at a later date, claims may be submitted with the KX modifier from the date of the re-evaluation.

8. If a patient fails to meet the requirements for additional coverage of PAP therapy beyond the 90-day trial period, when is that patient eligible for a new trial? Answer: In order to requalify for PAP therapy, the patient must undergo another face-to-face clinical evaluation and facility-based sleep test to assist in discerning the reasons for failure to demonstrate improvement in obstructive sleep apnea symptoms during the initial 90 day trial period.

9. Titration, either in-home or in-lab, is not addressed in the LCD. Will there be any opportunity for in-home titration? When? How? Under what circumstances? Answer: Titration may be performed either in-home or in-lab. Titration conducted in a facility-based setting is addressed in LCDs from other contractors. Titration conducted in the unattended home setting is not addressed in the PAP policy because there is no additional payment from the DME MAC for this procedure. If auto-titrating PAP devices are used for home titration, they should be billed using HCPCS code E0601.

10. Has there been any consideration to paying for A9279 - Compliance monitoring equipment or component of equipment, to compensate for the additional work on the part of the supplier associated with compliance in the initial 90-day trial period? Answer: This was considered; however, it has been decided that A9279 will continue to be non-covered by Medicare.

11. G0398, G0399 and G0400 were created for portable testing. How frequently can those be billed/paid and used to qualify a patient for PAP therapy? Answer: These are not codes payable by the DME MAC. Billing frequencies and payment amounts are established by other contractors.

12. Why are there several different effective dates in the PAP Device policy? Answer: The national coverage determination (NCD) became effective on March 13, 2008. The NCD required a clinical evaluation and demonstration of improvement in OSA symptoms in the first 12 weeks of PAP use. It also allowed the use of home sleep tests to qualify the patient for a PAP device. As is often the case, the NCD requirements needed further definition and explanation; therefore, those additional guidelines for coverage, coding and payment were included in the DME MAC LCD. A prospective effective date was given to allow compliance with those criteria.

13. Who is allowed to interpret sleep studies? Answer: The PAP policy requirements for interpreting physicians allows for sleep study interpretation by one of the following:

- Board certified in sleep medicine by the American Academy of Sleep Medicine (AASM); or,
- Board certified in sleep medicine by member board of the American Board of Medical Specialties (ABMS); or,
- Physician who has completed training in an ABMS member board specialty and is awaiting the next sleep medicine certification exam; or,
- Physician who is an active staff member of an AASM or Joint Commission-accredited sleep center or laboratory.

For home sleep tests, interpreting physicians must meet one of these 4 criteria by November 1, 2008. For physicians interpreting facility-based sleep tests, the timeline to meet one of these 4 criteria is January 1, 2010.

14. How can suppliers find out if a physician is board-certified? Answer: Suppliers may contact the physician directly or search the certification records of the ABMS (www.abms.org) member boards or AASM certification information (www.aasmnet.org/abms).

15. Does a change from an E0601 to E0470 after the 91st day require a physician face-to-face evaluation? Answer: Changing devices from a CPAP to RAD in the first 90 days can occur without a repeat face-to-face evaluation. It is anticipated that the physician and/or DME supplier is actively engaged with the patient to ensure that they are adherent to therapy and that any factors impacting the successful improvement in their OSA symptoms are being addressed. However once past the initial 90 days, changing from CPAP to RAD is often necessitated by complicating factors and must be done in conjunction with another face-to-face evaluation by the treating physician.