



MLN Matters[®]



Information for Medicare Fee-For-Service Health Care Professionals

Related Change Request (CR) #: 3843

MLN Matters Number: MM3843

Related CR Release Date: May 6, 2005

Related CR Transmittal #: 35

Effective Date: April 4, 2005

Implementation Date: June 6, 2005

Continuous Positive Airway Pressure (CPAP) Therapy for Obstructive Sleep Apnea (OSA)

Note: This article was updated on March 28, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers billing Medicare carriers, including Durable Medical Equipment Regional Carriers (DMERCs) and Fiscal Intermediaries (FIs) for OSA-related claims

Provider Action Needed

Providers need to be aware that on April 4, 2005, the Centers for Medicare & Medicaid Services (CMS) declared that the national coverage policy for CPAP therapy for OSA will remain unchanged. Unattended home sleep testing for the diagnosis of OSA is **not** considered reasonable and necessary. Polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

Background

CR3843 is updating and confirming the National Coverage Determination (NCD) policy section 240.4 of the Medicare NCD Manual (Pub. 100-03), which states that polysomnography must be performed in a facility-based sleep study laboratory, not in the home or a mobile facility.

The use of CPAP is covered under Medicare when used in adult patients with moderate or severe OSA for whom surgery is a likely alternative to CPAP. The use of CPAP devices must be ordered and prescribed by the licensed treating physician to be used in adult patients with moderate to severe OSA if either of the following criteria using the Apnea-Hypopnea Index (AHI) is met:

- AHI greater than or equal to 15 events per hour, or

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- AHI greater than or equal to 5 and less than or equal to 14 events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders or insomnia, or documented hypertension, ischemic heart disease, or history of stroke.

The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of 2 hours of sleep recorded by polysomnography using actual recorded hours of sleep (i.e., the AHI may not be extrapolated or projected). Apnea is defined as a cessation of airflow for at least 10 seconds.

Hypopnea is defined as an abnormal respiratory event lasting at least 10 seconds with at least a 30 percent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4 percent oxygen desaturation.

Initial claims must be supported by medical documentation (separate documentation where electronic billing is used), such as a prescription written by the patient's attending physician that specifies:

- A diagnosis of moderate or severe obstructive sleep apnea, and
- Surgery is a likely alternative.

The claim must also certify that the documentation supporting a diagnosis of OSA (described above) is available.

Additional Information

The HCPCS codes that can be used for billing covered Medicare CPAP devices and various accessories are E0601, A7030-A7039, A7044-A7046, and E0561-E0562.

For complete details, please see the official instruction issued to your carrier/DMERC/intermediary regarding this change. That instruction may be viewed by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R35NCD.pdf> on the CMS website.

For additional information relating to this issue, please refer to your carrier/DMERC/intermediary. To find their toll free phone numbers go to <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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