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Use of this template is voluntary / optional

Positive Airway Pressure (PAP) Device for OSA

Face to Face (F2F) Encounter Template Guidance

Purpose

This template is designed to assist a physician/Non-Physician Practitioner (NPP)[1] in documenting a face-to-face (F2F) encounter for Positive Airway Pressure (PAP) devices that meets requirements for Medicare eligibility and coverage. This template is available to the clinician and can be kept on file within the patient's medical record or can be used to develop an F2F encounter note for use with the system containing the patient's electronic medical record.

An F2F encounter is required by Medicare for the following PAP devices:

> **E0601** - CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) DEVICE
>
> **E0470** - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITHOUT BACKUP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

The F2F encounter must be completed within a 6-month timeframe prior to completion of the written order that starts use of PAP therapy for the treatment of your patient's diagnosed Obstructive Sleep Apnea (OSA).

Relevant information in the F2F documentation may include the following clinical elements:

- History (both present and past);
- Review of Systems (ROS) signs and symptoms of disordered breathing during sleep:
  - Snoring,
  - Daytime somnolence (CPAP – E0601 & Bi-Level PAP – E0470),
  - Observed apneic episodes,
  - Choking or gasping for breath during sleep,
  - Excessive fatigue,
  - Morning headache,
  - Cognitive dysfunction,
  - Dyspnea, etc.;
- Duration of symptoms;
- Validated sleep hygiene inventory (e.g., Epworth Sleepiness Scale);
- Pertinent physical exam findings;

[1] A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.

- Upper airway evaluation, (e.g., Nasal Septum, Nasal Passages/Mucosa, Soft Palate, Uvula, Oral Cavity, Posterior Oral Pharynx, Tonsils/Adenoids, etc.),

NOTE: For patients who require oxygen at night, in addition to and to be administered with their CPAP, the qualifying test for the oxygen must be conducted with the patient in a chronic stable state, (i.e., with PAP therapy their OSA is optimally treated). (Home Oxygen Therapy Templates.)

This template document is available to the clinician and can be kept on file with the patient's medical record or placed within the EHR of the patient's electronic medical record.

Patient Eligibility

Eligibility for use of a PAP device under Medicare requires a physician/ NPP to establish that coverage criteria are met as outlined below. This helps to ensure the PAP device to be provided is consistent with the physician's order and supported in the documentation of the patient's medical record.

The physician or allowed NPP must document that the patient has substantiated a diagnosis of Obstructive Sleep Apnea (OSA) supporting the need for use of a PAP device. The following National Coverage Determination (NCD – 240.4) provides criteria supporting the use of a PAP device:

- Adult patients diagnosed with OSA:
    - Initially limited to 12-week period to identify OSA patients that benefit from the use of CPAP,
    - CPAP is subsequently covered for OSA patients who have documented improvement or benefit during the initial 12-week period of CPAP therapy.
- Provider/supplier of CPAP must educate the patient or caregiver, if willing and able to safely operate the device, in the proper use of the CPAP device prior to use of the CPAP device;
- Confirmed diagnosis of OSA for coverage of a CPAP device must include a positive clinical evaluation using an approved sleep test methodology;
    - Attended PSG performed in a sleep laboratory, or
    - Unattended HST with a Type II home sleep monitoring device, or
    - Unattended HST with a Type III home sleep monitoring device, or
    - Unattended HST with a Type IV home sleep monitoring device that measures at least 3 channels;
    - The sleep test must have been previously ordered by the treating physician and furnished under appropriate physician supervision;
    - An initial 12-week period of CPAP is covered in adult patients with OSA if either of the following criterion using the AHI or RDI are met:
        - AHI or RDI greater than or equal to 15 events per hour, or
        - AHI or RDI greater than or equal to 5 events 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 or RDI is calculated on the average number of events of per hour. If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events to calculate the AHI or RDI during sleep testing must be at a minimum the number of events that would have been required in a 2-hour period.

- 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% reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a 4%2 oxygen desaturation.

NOTE: Respiratory Event-Related Arousals (RERAs) are not allow by Medicare in the calculation of the AHI or RDI.

Continued Medicare coverage of PAP (CPAP) after the initial 12 weeks of use is supported by the following:

- The medical documentation substantiates the patient benefited from the initial 12-week trial; or
- An F2F clinical re-evaluation by the treating practitioner was performed documenting that the symptoms of OSA during the initial 12-week trial improved (between days 31-91 after initiating therapy); and
- There is objective evidence of adherence to use of the PAP (CPAP).

Medicare coverage of a PAP (Bi-Level PAP) device (E0470) is reasonable and necessary if the patient's medical records substantiate one or more of the following:

- The clinical information in the documentation meets all the coverage criteria for a PAP (CPAP) device as outlined above;
- The medical documentation substantiates the patient with a primary diagnosis of OSA did not respond to or cannot tolerate a "Standard CPAP" device (E0601);
  - Confirmed during a titration PSG study; or
  - Documented as an assessment based on the patient's signs and symptoms as documented in the treating physician's clinical record.
- A new F2F evaluation was performed and documented after the beneficiary used an E0601 device for more than 3 months and was then switched to an E0470.

Who can complete the F2F encounter template?

A physician or allowed NPP who performs an F2F encounter:

- 6 months prior to completion of a WOPD for the initial PAP device; or
- At the time of re-evaluating the Medicare beneficiary for continued use of a PAP (CPAP) device (E0601); or
- Documenting that the Medicare beneficiary had used an E0601 without improvement and was a candidate for a Bi-Level PAP (E0470) device; or
- After use of an E0601 for 3 months and was then switched to an E0470.

Note: If this template is used:

1) CDEs in black Calibri are required
2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
3) CDEs in blue Times New Roman are recommended but not required

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[2] Medicare uses 4% oxygen desaturation in the calculation of the AHI and RDI. For Medicare coverage of PAP therapy, the AHI or RDI must be calculated using the 4% oxygen desaturation metric."

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Positive Airway Pressure (PAP) Device for OSA Face-to-Face (F2F) Encounter Template

Patient information:

Last name: _____First name: _____MI: _____

DOB (MM/DD/YYYY):_____ Gender: ____M ___F ___Other Medicare ID:_____

Provider (physician/NPP) who performed the F2F evaluation if different from signing provider:

Last name:_____First name: _____MI: ___Suffix:_____

NPI:_____

Date of encounter (MM/DD/YYYY):_____

Is this a F2F evaluation of the patient's need for a PAP device for OSA? ____Yes ____No

If Yes, is this ___ an initial evaluation or ___ a re-evaluation?

If re-evaluation, is there evidence of continued use of the PAP/CPAP device and supplies?

____Yes ____No Describe:_____

If No, purpose of the encounter:_____

Current patient diagnoses (check the following, if appropriate):

____Obstructive Sleep Apnea (G47.33)

Other Diagnoses

ICD-10	Description
_____	_____
_____	_____
_____	_____

Current sleep study results if available (If re-evaluation, result of prior sleep study):

Apnea-Hypopnea Index (AHI) _____ or Respiratory Disturbance index (RDI) _____ in events/hour

Symptoms: ___excessive daytime sleepiness, ___impaired cognition, ___mood disorder, ___insomnia,

___other, describe_____

History: ___hypertension, ____ischemic heart disease, ____history of stroke,

___other, describe_____

If re-evaluation for a bi-level pressure device E0470 (BiPAP without backup rate):

Was E0601 (CPAP) tried and not effective on therapeutic trial conducted in either a

___ facility, or _____in a home setting? ____Yes ____No

E0601 patient is not tolerating the therapy at current settings and lower pressures settings were tried and failed to: ____adequately control the symptoms of OSA, ___ improve sleep quality, or

___reduce the AHI/RDI to acceptable levels

Have you reviewed and signed the written report of adherence data? ___*Yes* ___*No*

Did patient use PAP device>= 4 hours per night on 70% of nights during consecutive 30-day period during the first three months of initial use? ___*Yes* ___*No*

Is the patient capable of being trained to use the device in an appropriate manner? ___Yes ___No

If no, is there a responsible care giver? ___*Yes* ___*No*

Chief complaint / history of present illness and associated signs / symptoms:_____

_____

_____

Related past medical / surgical history:_____

_____

Medications (Status: N=New, C=Current, M=Modified, D=Discontinued)

RxNorm	Description	Dose	Frequency	Route	Status

Other medications

Allergies (Include RxNorm if known)

RxNorm	Description	RxNorm	Description

Review of systems (Significant as per history of present problem and need for a PAP device for OSA):

General: ___weight gain, ___weight loss, ___sleeping problems, ___fatigue, ___fever, ___chills, ___night sweats / diaphoresis
___other:_____

Skin: ___pressure ulcers, ___rashes, ___changes in nails/hair, ___eczema, ___pruritus,
___other:_____

Lymphatic: ___swollen glands/masses: ___in the neck, ___axilla, ___groin,
___other:_____

Head: ___fainting, ___dizziness, ___headaches,
___other:_____

Eyes:	___diplopia, ___glasses/contact lenses, ____redness/discharge, ____blurred vision, ___glaucoma, ____cataracts, ___other:_____
Ears:	___tinnitus, ____discharge, ____hearing loss, ___other:_____
Nose:	___epistaxis, _____sinus infections, ____discharge, _____polyps, ___other:_____
Oral:	___dysphagia, ___hoarseness, ____teeth/dentures, ___other:_____
Neck:	___lumps, ___pain on movement ___other:_____
Breast:	___masses/tumors, ____tenderness, ____discharge, ____gynecomastia, ___other:_____
Pulmonary:	___cough, ___shortness of breath, ____pain, ___wheezing, ____hemoptysis, ___sputum production ___other:_____
Cardiac:	___chest pain, ___palpitations, ____orthopnea, ____murmur, ____syncope ___other:_____
Vascular:	___edema, ___claudication, ___varicose veins, ___thrombophlebitis, ____ulcers ___other:_____
Gastrointestinal:	___swallowing problems, ___abdominal pain, ___constipation, ___diarrhea, ___incontinence, ___nausea, ___vomiting, ____ulcers, _____melena, ____rectal bleeding, ___jaundice, ____heartburn, ___hematemesis ___other:_____
Renal:	___dysuria, ___frequency, _____urgency, ___hesitation, ____flank pain, ____hematuria, ___incontinence, ____nocturia, ___polyuria, ___other:_____
Musculoskeletal:	___pain, ___swelling, ____stiffness, ____limitation of range of motion, ____arthritis ___gout, ___cramps, _____myalgia, ___fasciculation, ____atrophy, ____fracture, ___deformity, _____weakness, ___other:_____
Neurologic:	___seizures, ___poor memory, ____poor concentration, ____numbness / tingling, ___pins and needles sensation, ___hyperpathia, _____dysesthesia, ____weakness, ___paralysis, ____tremors, ____involuntary movements, ____unstable gait, ____fall, ___vertigo, ___headache, ____stroke, ___speech disorders ___other:_____
Psychiatric:	___hallucinations, _____delusions, ____anxiety, ____nervous breakdown, ___mood changes ___other:_____

Hematology: ___anemia, ____bruising, ____bleeding disorders (conditional)
___other:_____

Endocrine: ___heat or cold intolerance, ____diabetes, ____lipid disorders, ____goiter
___other:_____

Other:_____

Physical examination:

Vital signs: T=_____P=_____R=_____BP=_____/_____Height=_____Weight=_____

O2 Sat:_____ (RA at Rest) O2 Sat:_____ (with supplemental O2 at _____LPM)

Neck circumference:_____ cm Body mass index (BMI)_____

General appearance:_____

Head and neck:_____

Chest / lungs:_____

Cardiovascular:_____

Abdominal:_____

Musculoskeletal / extremities:_____

Neurological:_____

Psychiatric:_____

Visual Exam:_____

Other:_____

Physician/NPP assessment / summary: _____

_____

_____

_____

Treatment plan:

_____

_____

_____

Orders:

Medications (other than immunosuppressive drugs): _____

_____

Supplies: _____

_____

Investigations (Diagnostic Testing): _____

_____

Consults: _____

_____

Other: _____

_____

_____

Signature, Name, Date and NPI of physician or allowed NPP

Signature: _____

Name (Printed): _____

Date (MM/DD/YYYY): _____ NPI: _____