

LMRP for Continuous Positive Airway Pressure System (CPAP) (L11528)**Contractor Information**

Contractor Name	<u>Tricenturion</u>
Contractor Number	77011
Contractor Type	DMERC

LMRP Information

LMRP Database ID Number	L11528
LMRP Title	Continuous Positive Airway Pressure System (CPAP)
Original Policy Effective Date	For services performed on or after 10/01/1993
Original Policy Ending Date	
Revision Effective Date	For services performed on or after 01/01/2004
Revision Ending Date	
Contractor's Policy Number	CPAP20040101
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CMS National Coverage Policy	CMS Pub. 100-03, Rev. 1, Chapter 1, Section 240.4
<u>Primary Geographic Jurisdiction</u>	CT DE MA ME NH NJ

NY
PA
RI
VT

Oversight Region

Region III

CMS Consortium

Northeast

DMERC Region LMRP Covers

Region A

LMRP Description

Continuous positive airway pressure (CPAP) devices, accessories and supplies.

Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must: 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted to the DMERC. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

INITIAL COVERAGE:

A single level continuous positive airway pressure (CPAP) device (E0601) is covered if the patient has a diagnosis of obstructive sleep apnea (OSA) documented by an attended, facility-based polysomnogram and meets either of the following criteria (1 or 2):

- 1) The AHI is greater than or equal to 15 events per hour, or
- 2) The AHI is from 5 to 14 events per hour with documented symptoms of:
 - a) Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
 - b) Hypertension, ischemic heart disease, or history of stroke.

If a continuous positive airway pressure device (E0601) is provided and the criteria above have not been met, it will be denied as not medically necessary.

For the purpose of this policy, polysomnographic studies must be performed in a facility based sleep study laboratory, and not in the

home or in a mobile facility. These labs must be qualified providers of Medicare services and comply with all applicable state regulatory requirements.

For the purpose of this policy, polysomnographic studies must not be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests.

If there is discontinuation of usage of an E0601 device at any time, the supplier is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:

Continued coverage of an E0601 device beyond the first three months of therapy requires that, no sooner than the 61st day after initiating therapy, the supplier ascertain from either the beneficiary or the treating physician that the beneficiary is continuing to use the CPAP device.

If the above criterion is not met, continued coverage of an E0601 device and related accessories will be denied as not medically necessary.

ACCESSORIES:

Accessories used with an E0601 device are covered when the coverage criteria for the device are met. Accessories are separately reimbursable at the time of initial issue and when replaced.

The following table represents the usual maximum amount of accessories expected to be medically necessary:

A7032/A7033 - 2 per 1 month
A7034 - 1 per 3 months
A7035 - 1 per 6 months
A7036 - 1 per 6 months
A7037 - 1 per 1 month
A7038 - 2 per 1 month
A7039 - 1 per 6 months

Quantities of supplies greater than those described in the policy as the usual maximum amounts, in the absence of documentation clearly explaining the medical necessity of the excess quantities, will be denied as not medically necessary.

Either a non-heated (E0561) or heated (E0562) humidifier is covered when ordered by the treating physician for use with a covered E0601 device.

CPT/HCPCS Section

Durable Medical Equipment
Durable Medical Equipment Regional DMERCs

Benefit Category

Durable Medical Equipment

Coding Information

CPT/HCPCS Codes

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY - No physician or other health care provider order for this item or service.

KX - Specific required documentation on file.

EQUIPMENT

E0601 CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE

ACCESSORIES

A7030 FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

A7031 FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH

A7032 REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE, EACH

A7033 REPLACEMENT PILLOWS FOR NASAL APPLICATION DEVICE, PAIR

A7034 NASAL INTERFACE (MASK OR CANNULA TYPE) USED WITH POSITIVE AIRWAY PRESSURE DEVICE, WITH OR WITHOUT HEAD STRAP

A7035 HEADGEAR USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7036 CHINSTRAP USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7037 TUBING USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7038 FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7039 FILTER, NON DISPOSABLE, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

A7044 ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH

A7046 WATER CHAMBER FOR HUMIDIFIER, USED WITH POSITIVE AIRWAY PRESSURE DEVICE, REPLACEMENT, EACH

E0561 HUMIDIFIER, NON-HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

E0562 HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRESSURE DEVICE

ICD-9 Codes that Support Medical Necessity

Not specified.

Diagnoses that Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not specified.

Reasons for Denials

Items listed in this policy will be denied as not medically necessary when provided for conditions other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section unless it specifically states in that section that they will be denied as noncovered.

Non-covered ICD-9 Codes

Non-covered Diagnoses

Not specified.

Coding Guidelines

A continuous positive airway pressure (CPAP) device (E0601) delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs.

For auto-titrating CPAP devices use HCPCS code E0601.

Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.

General Information

Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 1395l(e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DMERC upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request. Items billed to the DMERC before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

When billing for quantities of supplies greater than those described in the policy as the usual maximum amounts, each claim must include documentation supporting the medical necessity for the higher utilization. This information must be attached to a hard copy claim or entered into the narrative field of an electronic claim. Additionally, there must be clear documentation in the patient's medical records that corroborate the order and any additional documentation that pertains to the medical necessity of the items and quantities billed.

Proper use of the KX modifier is discussed below. The KX modifier must not be used on claims submitted to the DMERC until the requirements outlined in the documentation section have been met.

INITIAL COVERAGE (FIRST THREE MONTHS):

On claims for the first through third months, suppliers must add a KX modifier to codes for equipment (E0601) and accessories only if all of the criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy ("Initial Coverage") have been met. If the requirements for the KX modifier are not met, the supplier may submit additional documentation with the claim to justify coverage, but the KX modifier must not be used.

CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:

On the fourth month's claim (and any month thereafter), the supplier must add a KX modifier to codes for equipment (E0601) and accessories only if both the "Initial Coverage" criteria and the "Continued Coverage" criteria in the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy have been met. Suppliers must maintain documentation in their records that these criteria have been met and this must be available to the DMERC upon request.

If the supplier does not obtain information that the beneficiary is continuing to use the CPAP device in time for submission of the fourth or succeeding months' claims, the supplier may still submit the claims, but a KX modifier must not be added. However, if the supplier chooses to hold claims for the fourth and succeeding months until they determine that the beneficiary is continuing to use the device, those claims may then be submitted with the KX modifier.

Refer to the Supplier Manual for more information on documentation requirements.

Appendices

Footnotes

Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Other Comments

DEFINITIONS:

A respiratory cycle is defined as an inspiration, followed by an expiration.

Polysomnography is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). It must also include at least the following additional parameters of sleep: airflow, respiratory effort, and oxygen saturation by oximetry. It may be performed as either a whole night study for diagnosis only or as a split night study to diagnose and initially evaluate treatment.

Apnea is defined as the cessation of airflow for at least 10 seconds documented on a polysomnogram.

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

The apnea-hypopnea index (AHI) is defined as the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected.

Sources of Information and Basis for Decision

Reserved for future use.

Advisory Committee Meeting Notes

Start Date of Comment Period

04/30/1993

End Date of Comment Period 06/14/1993

Start Date of Notice Period 08/01/1993

Revision History Number CPAP006

Revision History Explanation

Revision Effective Date: 01/01/2004
HCPCS CODES AND MODIFIERS:
Crosswalked codes K0268 and K0531 to E0561 and E0562, respectively. Added new code A7046
OTHER COMMENTS:
Revised the definition of AHI to require a minimum of two hours of recording time without the use of the device rather than two hour of recorded sleep.

Revision Effective Date: 04/01/2003
HCPCS CODES AND MODIFIERS:
Added: A7030 – A7039, A7044, EY
Discontinued: K0183 – K0189
INDICATIONS AND LIMITATIONS OF COVERAGE:
Adds standard language concerning coverage of items without an order.
Updated utilization table to incorporate new A codes which were crosswalked from K codes.
Removed reference to RDI in definitions section.
DOCUMENTATION REQUIREMENTS:
Adds standard language concerning use of EY modifier for items without an order.

The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.

07/01/2002 – Revised language regarding who is a qualified provider of polysomnographic studies.

04/01/2002 – Updated Coverage and Payment Rules section to reflect National Coverage Decision to cover CPAP based on apnea-hypopnea index. Eliminated Certificate of Medical Necessity requirement. Added KX modifier to indicate coverage criteria met. Revised verbiage of HCPCS code K0184. Allowed coverage of either heated or non-heated humidifier with a covered CPAP device.

10/01/1995 – Added HCPCS codes for accessories.

12/01/1993 – Corrected typo from HAO to HA0 in the Documentation section.

Last Reviewed on Date

**Disclaimer Specialty
Name**

LMRP Attachments There are no attachments for this LMRP