

# **LCD for Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea (L171)**

## **Contractor Information**

### **Contractor Name**

Noridian Administrative Services

### **Contractor Number**

19003

### **Contractor Type**

DME MAC

## **LCD Information**

### **LCD ID Number**

L171

### **LCD Title**

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

### **Contractor's Determination Number**

PAP

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### **CMS National Coverage Policy**

CMS Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 240.4

### **Primary Geographic Jurisdiction**

Alaska  
American Samoa  
Arizona  
California - Entire State  
Guam  
Hawaii  
Iowa  
Idaho  
Kansas  
Missouri - Entire State  
Montana  
North Dakota

## LCD Information

### LCD ID Number

Nebraska  
Nevada  
Oregon  
South Dakota  
Utah  
Washington  
Wyoming  
Northern Mariana Islands

### Oversight Region

Region X

### DME Region LCD Covers

Jurisdiction D

### Original Determination Effective Date

For services performed on or after 10/01/1993

### Original Determination Ending Date

### Revision Effective Date

For services performed on or after 03/13/2008

### Revision Ending Date

### 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. 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:

## LCD Information

### LCD ID Number

A single level continuous positive airway pressure (CPAP) device (E0601) is covered for the treatment of obstructive sleep apnea (OSA) if criteria A - C are met:

- A. The patient has a face-to-face clinical evaluation by the treating physician prior to the sleep test to assess the patient for obstructive sleep apnea.

For dates of service on or after September 1, 2008, the clinical evaluation by the treating physician must include, at a minimum:

1. Sleep history and symptoms including, but not limited to, snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches; and,
2. Epworth Sleepiness Scale (See Appendices); and,
3. Physical examination that documents body mass index, neck circumference and a focused cardiopulmonary and upper airway system evaluation.

- B. The patient has a Medicare-covered sleep test that meets either of the following criteria (1 or 2):

1. The apnea-hypopnea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or,
2. The AHI or RDI greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of:
  - a. Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or,
  - b. Hypertension, ischemic heart disease, or history of stroke.

- C. The patient and/or their caregiver has received instruction from the supplier of the CPAP device and accessories in the proper use and care of the equipment.

## LCD Information

### LCD ID Number

If a claim for a CPAP (E0601) is submitted and all of the criteria above have not been met, it will be denied as not medically necessary.

Apnea is defined as the cessation of airflow for at least 10 seconds.

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 apnea and hypopnea per hour of sleep without the use of a positive airway pressure device.

The respiratory disturbance index (RDI) is defined as the average number of apneas plus hypopneas per hour of recording without the use of a positive airway pressure device.

If the AHI or RDI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events used to calculate the AHI must be at least the number of events that would have been required in a 2 hour period (i.e., must reach 30 events without symptoms or 10 events with symptoms).

#### Respiratory Assist Devices (RAD)

A RAD without backup rate (E0470) is covered for those patients with OSA who meet criteria A-C above, in addition to criterion D:

- D. A single level (E0601) positive airway pressure device has been tried and proven ineffective, based on a therapeutic trial conducted in either a facility or in a home setting.

If E0470 is billed and criterion D is not met, payment will be based on the allowance for the least costly medically appropriate alternative, E0601.

A RAD with backup rate (E0471) is not medically necessary if the primary diagnosis is OSA; therefore, if E0471 is billed with a diagnosis of OSA, the following payment rules apply:

1. If criteria A - D above are met, payment will be based on the allowance for the least costly medically appropriate alternative, E0470; or,
2. If criteria A-C above are met but not criterion D, payment will be based on the allowance for the least costly medically appropriate alternative, E0601.

If a CPAP device is tried and found ineffective during the initial 3 month home trial, substitution of a RAD does not require a new initial face-to-face clinical evaluation or a new sleep test.

## LCD Information

### LCD ID Number

If a CPAP device has been used for more than 3 months and the patient is switched to a RAD, a new initial face-to-face clinical evaluation is required, but a new sleep test is not required. A new 3 month trial would begin for use of the RAD.

Coverage, coding and documentation requirements for the use of RADs for diagnoses other than OSA are addressed in the RAD policy.

### Sleep Tests

Coverage and Payment rules for sleep tests may be found in the local coverage determinations (LCDs) for the applicable Medicare Part A or Part B contractor. There may be differences between those LCDs and the DME MAC LCD. For the purposes of coverage of PAP therapy, the DME MAC coverage, coding and payment rules take precedence.

Coverage of a PAP device for the treatment of OSA is limited to claims where the diagnosis of OSA is based upon a Medicare-covered sleep test (Type I, II, III, IV or Watch-PAT 100). A Medicare-covered sleep test must be either a polysomnogram performed in a facility-based laboratory (Type I study) or a home sleep test (HST) (Types II, III, IV, or Watch-PAT 100). The test must be ordered by the beneficiary's treating physician and conducted by an entity that qualifies as a Medicare provider of sleep tests and is in compliance with all applicable state regulatory requirements.

A Type I sleep test is the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep with physician review, interpretation, and report. It is facility-based and must include sleep staging, which is defined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), submental electromyogram (EMG) and electrocardiogram (ECG). 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.

An HST is performed unattended in the beneficiary's home using a portable monitoring device. A portable monitoring device for conducting an HST must meet one of the following criteria:

- A. Type II device – Monitors and records a minimum of seven (7) channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort and oxygen saturation; or,
- B. Type III device – Monitors and records a minimum of four (4) channels: 2 respiratory movement/airflow, ECG/heart rate and oxygen saturation; or,
- C. Type IV device – Monitors and records a minimum of three (3) channels that must include respiratory effort, airflow and oxygen saturation.
- D. Watch-PAT100 (Itamar Medical)

Watch-PAT100 does not measure airflow; therefore, the RDI or AHI derived does not meet the previously listed definitions for apnea or hypopnea. However, Watch-PAT 100 is considered a Medicare-covered HST for the purposes of this policy and the RDI derived must meet the threshold values listed in criterion B above for coverage.

## **LCD Information**

### **LCD ID Number**

For dates of service on or after September 1, 2008, all beneficiaries who undergo a HST must, prior to having the test, receive a face-to-face demonstration of how to properly apply a portable sleep monitoring device. This education must be provided by the entity conducting the HST and may not be performed by a DME supplier.

For dates of service on or after September 1, 2008, all sleep tests must be interpreted by a physician who is either:

1. A diplomat of the American Board of Sleep Medicine (ABSM); or,
2. Diplomat in Sleep Medicine by a member board of the American Board of Medical Specialties (ABMS); or,
3. An active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations – JCAHO).

No aspect of a HST, including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests.

### **CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:**

Continued coverage of a PAP device (E0470 or E0601) beyond the first three months of therapy requires that, no sooner than the 61st day but no later than the 91st day after initiating therapy, the treating physician must conduct a clinical re-evaluation and document that the beneficiary is benefiting from PAP therapy.

For dates of service on or after September 1, 2008, documentation of clinical benefit is demonstrated by:

1. Face-to-face clinical re-evaluation by the treating physician with documentation that symptoms of obstructive sleep apnea are improved; and,
2. Objective evidence of adherence to use of the PAP device.

Adherence to therapy is defined as use of PAP 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage.

If the above criteria are not met, continued coverage of a PAP device and related accessories will be denied as not medically necessary.

If the physician re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the patient is benefiting from PAP therapy as defined in criteria 1 and 2 above, continued coverage of the PAP device will commence with the date of that re-evaluation.

If a CPAP device is tried and found ineffective during the initial 3 month home trial, substitution of a RAD (E0470) does not change the length of the trial. The clinical re-evaluation would occur between the 61st and 91st day following the initiation of CPAP.

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If a CPAP device was used for more than 3 months and the patient was switched to a RAD, then the clinical re-evaluation would occur between the 61st and 91st day following the initiation of the RAD. There would also need to be documentation of adherence to therapy during the 3 month trial with the RAD.

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

For a PAP device dispensed prior to September 1, 2008, if the initial coverage criteria in effect at the time were met and the criteria for coverage after the first 3 months that were in effect at the time were met, the device will continue to be covered for dates of service on or after September 1, 2008 as long as the patient continues to compliantly use the device.

### ACCESSORIES:

Accessories used with a PAP device are covered when the coverage criteria for the device are met. If the coverage criteria are not met, the accessories will be denied as not medically necessary.

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

A4604 – 1 per 3 months  
A7027 - 1 per 3 months  
A7028 – 2 per 1 month  
A7029 – 2 per 1 month  
A7030 – 1 per 3 months  
A7031 – 1 per 1 month  
A7032 - 2 per 1 month  
A7033 – 2 per 1 month  
A7034 - 1 per 3 months  
A7035 - 1 per 6 months  
A7036 - 1 per 6 months  
A7037 - 1 per 3 months  
A7038 - 2 per 1 month  
A7039 - 1 per 6 months  
A7046 – 1 per 6 months

Quantities of supplies greater than those described in the policy as the usual maximum amounts 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 PAP (E0470 or E0601) device.

### Coverage Topic

## LCD Information

### LCD ID Number

Durable Medical Equipment

## Coding Information

### Bill Type Codes:

**Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.**

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TBD

### Revenue Codes:

**Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.**

### CPT/HCPCS Codes

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

#### HCPCS MODIFIERS:

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

KX - Specific required documentation on file.

#### EQUIPMENT

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)

E0471

RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPABILITY, WITH BACK-UP RATE FEATURE, USED WITH NONINVASIVE INTERFACE, E.G., NASAL OR FACIAL MASK (INTERMITTENT ASSIST DEVICE WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE)

## Coding Information

### Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

E0601	CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE
ACCESSORIES	
A4604	TUBING WITH INTEGRATED HEATING ELEMENT FOR USE WITH POSITIVE AIRWAY PRESSURE DEVICE
A7027	COMBINATION ORAL/NASAL MASK, USED WITH CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7028	ORAL CUSHION FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, EACH
A7029	NASAL PILLOWS FOR COMBINATION ORAL/NASAL MASK, REPLACEMENT ONLY, PAIR
A7030	FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7031	FACE MASK INTERFACE, REPLACEMENT FOR FULL FACE MASK, EACH
A7032	CUSHION FOR USE ON NASAL MASK INTERFACE, REPLACEMENT ONLY, EACH
A7033	PILLOW FOR USE ON NASAL CANNULA TYPE INTERFACE, REPLACEMENT ONLY, 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	

## Coding Information

### Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

	ORAL INTERFACE USED WITH POSITIVE AIRWAY PRESSURE DEVICE, EACH
A7045	EXHALATION PORT WITH OR WITHOUT SWIVEL USED WITH ACCESSORIES FOR POSITIVE AIRWAY DEVICES, REPLACEMENT ONLY
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

The presence of an ICD-9 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on Indications and Limitation of Coverage and/or Medical Necessity for other coverage criteria and payment information.

327.23	OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
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### Diagnoses that Support Medical Necessity

All diagnoses that are specified in the preceding section.

### ICD-9 Codes that DO NOT Support Medical Necessity

All ICD-9 codes that are not specified in the preceding section.

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

## Coding Information

### Bill Type Codes:

**Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.**

### Diagnoses that DO NOT Support Medical Necessity

All diagnoses that are not specified in the preceding section.

## 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". 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 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 upon request. Items billed 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.

The ICD-9 code that justifies the need for the item must be included on the claim.

Physicians shall document the face-to-face clinical evaluations (initial and follow-up) in a detailed narrative note in their charts in the format that they use for other entries.

The re-evaluation must take place within the first 3 months of treatment; however, formal assessment of improvement cannot be documented before the 61st day. The follow-up evaluation must document both improvement in subjective symptoms of OSA and objective data related to adherence to PAP therapy.

Documentation of adherence to PAP therapy shall be accomplished through direct download of usage data. This information does not have to be submitted with the claim but must be available upon request.

Many suppliers have created forms which have not been approved by CMS which they send to physicians and ask them to complete. Even if the physician completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate physicians on the type of information that is needed to document a patient's need for PAP therapy.

Proper use of the KX modifier is discussed below. The KX modifier must not be used on claims submitted 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 PAP equipment (E0470 or 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.

## General Information

### Documentation Requirements

#### 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 PAP equipment (E0470 or 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 upon request.

If the supplier does not obtain information from the physician that the beneficiary has demonstrated improvement in their OSA symptoms and is adhering to PAP therapy 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.

If the supplier chooses to hold claims for the fourth and succeeding months pending receipt of information from the treating physician that the beneficiary received a clinical re-evaluation between the 61st and 91st day, had documented improvement in OSA symptoms and is adhering to PAP therapy, those claims may then be submitted with the KX modifier.

If the supplier chooses to hold claims for the fourth and succeeding month pending receipt of information from the treating physician but learns that the beneficiary did not receive a clinical re-evaluation between the 61st and 91st day but rather was re-evaluated at a later date and had documented improvement in OSA symptoms and is adhering to PAP therapy, those claims may then be submitted with the KX modifier but only for dates of service following the date of the clinical re-evaluation.

For a PAP device dispensed prior to September 1, 2008, if the initial coverage criteria in effect at the time were met and the criteria for coverage after the first 3 months that were in effect at the time were met, the KX modifier may be added to claim with dates of service on or after September 1, 2008 as long as the patient continues to compliantly use the device.

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

### Appendices

#### EPWORTH SLEEPINESS SCALE

*How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.*

*Use the following scale to choose the most appropriate number for each situation:*

- 0 = would *never* doze or sleep
- 1 = *slight* chance of dozing or sleeping
- 2 = *moderate* chance of dozing or sleeping
- 3 = *high* chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
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## General Information

### Documentation Requirements

Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
<b>Total score (add the scores up)</b> (This is your Epworth score)	_____

<0-9 - Average score, normal population

## **General Information**

### **Documentation Requirements**

Epworth Sleepiness Scale reprinted with permission of the Associated Professional Sleep Societies (Johns MW; A New Method for Measuring Daytime Sleepiness: The Epworth Sleepiness Scale. SLEEP 1991;14(6):540-545).

### **Utilization Guidelines**

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

### **Sources of Information and Basis for Decision**

### **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**

CPAP010

### **Revision History Explanation**

Revision Effective Date: 3/13/2008 except where noted otherwise in the LCD.

Changed title from CPAP Device to Positive Airway Pressure Devices for the Treatment of OSA to reflect addition of coverage for bilevel devices.

#### **INDICATIONS AND LIMITATIONS OF COVERAGE:**

Added: Revised coverage criteria for CPAP to include home sleep testing and face-to-face clinical evaluation and re-evaluation.

Moved: Use of bilevel devices (E0740 and E0741) for OSA from the Respiratory Assist Devices LCD to this LCD.

Added: Coverage criteria for changing from a CPAP to RADs both before and after the first three months of PAP therapy.

Added: Definition of adherence

Added: Criteria for portable sleep monitoring devices

Added: Requirements for administering and interpreting home sleep studies

Moved: Information previously contained in Appendices.

#### **DOCUMENTATION:**

Added: Information about documenting adherence and clinical re-evaluation

## **General Information**

### **Documentation Requirements**

Added: Grandfathered patients and the use of the KX modifier.

Revised: Use of KX modifier for claims in fourth and subsequent months

#### **APPENDICES**

Added: Epworth Sleepiness Scale

3/1/2008- In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC Noridian Administrative Services (19003) LCD L171 from DME PSC Electronic Data Systems Corp. (77006) LCD L171.

Revision Effective Date: 01/01/2008

#### **INDICATIONS AND LIMITATIONS OF COVERAGE:**

Added: Usual maximum quantity parameters for new HCPCS codes - A7027, A7028, A7029

#### **HCPCS CODES:**

Added: A7027, A7028, A7029

Removed: K0553, K0554, K0555

Revision Effective Date: 07/01/2007

#### **INDICATIONS AND LIMITATIONS OF COVERAGE:**

Removed: DMERC references.

Revised: Usual maximum quantity parameter for A7037.

Added: Usual maximum quantity parameters for new HCPCS codes – K0553, K0554 and K0555.

#### **HCPCS CODES AND MODIFIERS:**

Added: K0553, K0554 and K0555

#### **DOCUMENTATION REQUIREMENTS:**

Removed: DMERC references.

Revision Effective Date: 03/01/2006

In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC Electronic Data Systems Corp. (77006) from DMERC CIGNA Government Services (05655).

Revision Effective Date: 01/01/2006

#### **HCPCS CODES:**

Added: A4604

Revised: A7032, A7033

#### **INDICATIONS AND LIMITATIONS OF COVERAGE:**

Accessories:

Added frequency guideline for A4604, A7030 and A7046.

Added clarification regarding Full Face Mask Seals (A7031)

#### **DOCUMENTATION REQUIREMENTS:**

Revised requirements for documenting excess quantities of supplies.

#### **APPENDICES:**

Revised definition of apnea-hypopnea index (AHI) to reflect NCD.

Revision Effective Date: 01/01/2005

#### **HCPCS CODES AND MODIFIERS:**

Added: A7045

#### **APPENDICES:**

Clerical correction to move definitions from Policy Article to LCD.

Clarified calculation of AHI.

Revision Effective Date: 07/01/2004

LMRP converted to LCD and Policy Article.

#### **INDICATIONS AND LIMITATIONS OF COVERAGE:**

## **General Information**

### **Documentation Requirements**

Clarified how accessories are denied when medical necessity is not met.

Revision Effective Date: 01/01/2004

#### **HCPCS CODES AND MODIFIERS:**

Crosswalked codes E0561 and E0562 to K0268 and K0531, 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 hours 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:**

Added 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:**

Added 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.

### **Reason for Change**

CMS Requirement

### **Last Reviewed On Date**

07/10/2008

### **Related Documents**

**Article(s)**

## **General Information**

### **Documentation Requirements**

A19827 - Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article - Effective March 2008

### **LCD Attachments**

There are no attachments for this LCD.

### **Other Versions**

Updated on 07/11/2008 with effective dates 03/13/2008 - N/A

Updated on 07/10/2008 with effective dates 03/13/2008 - N/A

Updated on 03/13/2008 with effective dates 01/01/2008 - 03/12/2008

Updated on 03/05/2008 with effective dates 07/01/2007 - 12/31/2007